

7463

CERTIFICATE OF DEATH

07450

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. STREET ADDRESS Davidsonville (Rural)			
3. NAME OF DECEASED (Type or print) First Larmont Middle Austin Last ALLEN				4. DATE OF DEATH Month July Day 1 Year 19 59			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1959	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jerome Austin ALLEN				14. MOTHER'S MAIDEN NAME Althea Imelda Frances PROCTOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Hospital records.		INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c) 2 days							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 29, 1959 , to July 1, 1959 , that I last saw the deceased alive on July 1, 1959 , and that death occurred at 2:20PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Clayton Norton M.D.				ADDRESS (Street, city or town, state) 95 Cathedral St.,		DATE SIGNED 7/1/59	
PHYSICIAN'S NAME (Type) Clayton Norton				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-59		22c. NAME OF CEMETERY OR CREMATORY Our Lady of Mercy		22d. LOCATION (City, town, or county) (State) Owensville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III				ADDRESS Annapolis Md.		24a. REC'D BY REGISTRAR DATE JUL 9 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7498

CERTIFICATE OF DEATH

Reg. Dist. No.

07451

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pines on the Severn</u>		e. STREET ADDRESS <u>Pines on the Severn</u>	
3. NAME OF DECEASED (Type or print) <u>Olive Emma Anderson</u>		4. DATE OF DEATH <u>July 19 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28-1876</u>
9. AGE (In years, last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13. FATHER'S NAME <u>Edward S. Lindsay</u>		14. MOTHER'S MAIDEN NAME <u>Mary Emma Ellis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Brooks Anderson</u>		18. ADDRESS <u>Chestertown Md.</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO (b) <u>Myocarditis with fibrillation</u> DUE TO (c) <u>Maternal Arterial Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>About 18 hrs</u> <u>A year or more</u> <u>Procedural</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-5-</u> 19 <u>59</u> , to <u>7-19-</u> 19 <u>59</u> , that I last saw the deceased alive on <u>7/19-</u> 19 <u>59</u> , and that death occurred at <u>5:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Oliver Purvis</u>		ADDRESS (Street, city or town, state) <u>402 Franklin St. Annapolis Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. OLIVER PURVIS</u>		DATE SIGNED <u>7/20/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 23-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rural Cemetery</u>		22d. LOCATION (City, town, or county) <u>Albany N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sr.</u>		24a. REC'D BY REGISTRAR <u>—</u>	
ADDRESS <u>Annapolis Md.</u>		DATE <u>JUL 22 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		24c. REGISTRAR'S SIGNATURE <u>—</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7464 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07452

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>P.G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
				<u>Mitchellville</u>		<u>16X-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.D.H. - A.A. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Arnold</u> Last <u>Jr.</u>				4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12.13. 1914</u>		9. AGE (In years last birthday) <u>44</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George T. Arnold, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Quander</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W.# 2 214-40-5590</u>		17. INFORMANT <u>Mrs. Rachel Pemberton</u> Address <u>4035 Webster St., N. Brentwood, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury Anterior Chest</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - R301</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>7-18</u> p. m. <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>MAco MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7.23.59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Srlington Nat'l. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. McGuire</u>				ADDRESS <u>1820 9th St., N.W. Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 22 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deceased is a minor, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01.58

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF EXAMINATION

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF EXAMINATION

[Faint, illegible text and markings on the form, including what appears to be a signature and various fields.]



7499

CERTIFICATE OF DEATH

Reg. Dist. No.

07453

1. PLACE OF DEATH a. COUNTY A.A.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cuth Hill		c. LENGTH OF STAY IN 1b 1 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cuth Hill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glens Burnie				d. STREET ADDRESS -	
3. NAME OF DECEASED (Type or print) First Mary B. Baskinick Middle Last		4. DATE OF DEATH 7 Month 20 Year 1959			
5. SEX Female Negro		6. COLOR OR RACE MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7. DATE OF BIRTH Dec. 12, 1888 9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give last of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Cuth Hill, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -		17. INFORMANT Elychelly Bly Address Glens Burnie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL BRONCHOPNEUMONIA 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIO-VASC. DISEASE DUE TO (c) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 24 HRS 3 YEARS 10 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -	
20f. (City or town) -		20g. (County) -		20h. (State) -	
21. I certify that I attended the deceased from DEC 9 , 19 58 to JULY 20 , 19 59 , that I last saw the deceased alive on JULY 20 , 19 59 , and that death occurred at 6:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mountain Rd. DATE SIGNED 7-20-59		ACTUAL SIGNATURE Arthur Lankford Jr.		PHYSICIAN'S NAME (Type) ARTHUR LANKFORD JR MD Pasadena, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 7-24-59		22c. NAME OF CEMETERY OR CREMATORY Glens Burnie	
22d. LOCATION (City, town or county) Md.		22e. (State) Md.		22f. REGISTRAR'S SIGNATURE Arthur Lankford	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas E. Kelly		ADDRESS 1309		24. REC'D BY REGISTRAR JUL 22 59	

TO HOSPITAL DEPARTMENT ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7-10-19

07-15-19

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Cause of Death		Date of Death		Time of Death	
Place of Death		Occupation		Education	
Manner of Death		Signature of Physician		Signature of Registrar	
Date of Report		Signature of Reporter		Signature of Coroner	
Signature of Medical Examiner		Signature of Pathologist		Signature of Anatomist	
Signature of Forensic Pathologist		Signature of Toxicologist		Signature of Bacteriologist	
Signature of Chemist		Signature of Radiologist		Signature of Histologist	
Signature of Microscopist		Signature of Entomologist		Signature of Botanist	
Signature of Zoologist		Signature of Geologist		Signature of Meteorologist	
Signature of Astronomer		Signature of Physicist		Signature of Mathematician	
Signature of Engineer		Signature of Architect		Signature of Surveyor	
Signature of Lawyer		Signature of Judge		Signature of Clerk	
Signature of Notary Public		Signature of Sheriff		Signature of Marshal	
Signature of Constable		Signature of Jailor		Signature of Prisoner	
Signature of Prison Guard		Signature of Prison Warden		Signature of Prison Chaplain	
Signature of Prison Doctor		Signature of Prison Nurse		Signature of Prison Cook	
Signature of Prison Janitor		Signature of Prison Porter		Signature of Prison Watchman	
Signature of Prison Guard		Signature of Prison Warden		Signature of Prison Chaplain	
Signature of Prison Doctor		Signature of Prison Nurse		Signature of Prison Cook	
Signature of Prison Janitor		Signature of Prison Porter		Signature of Prison Watchman	

7465

CERTIFICATE OF DEATH

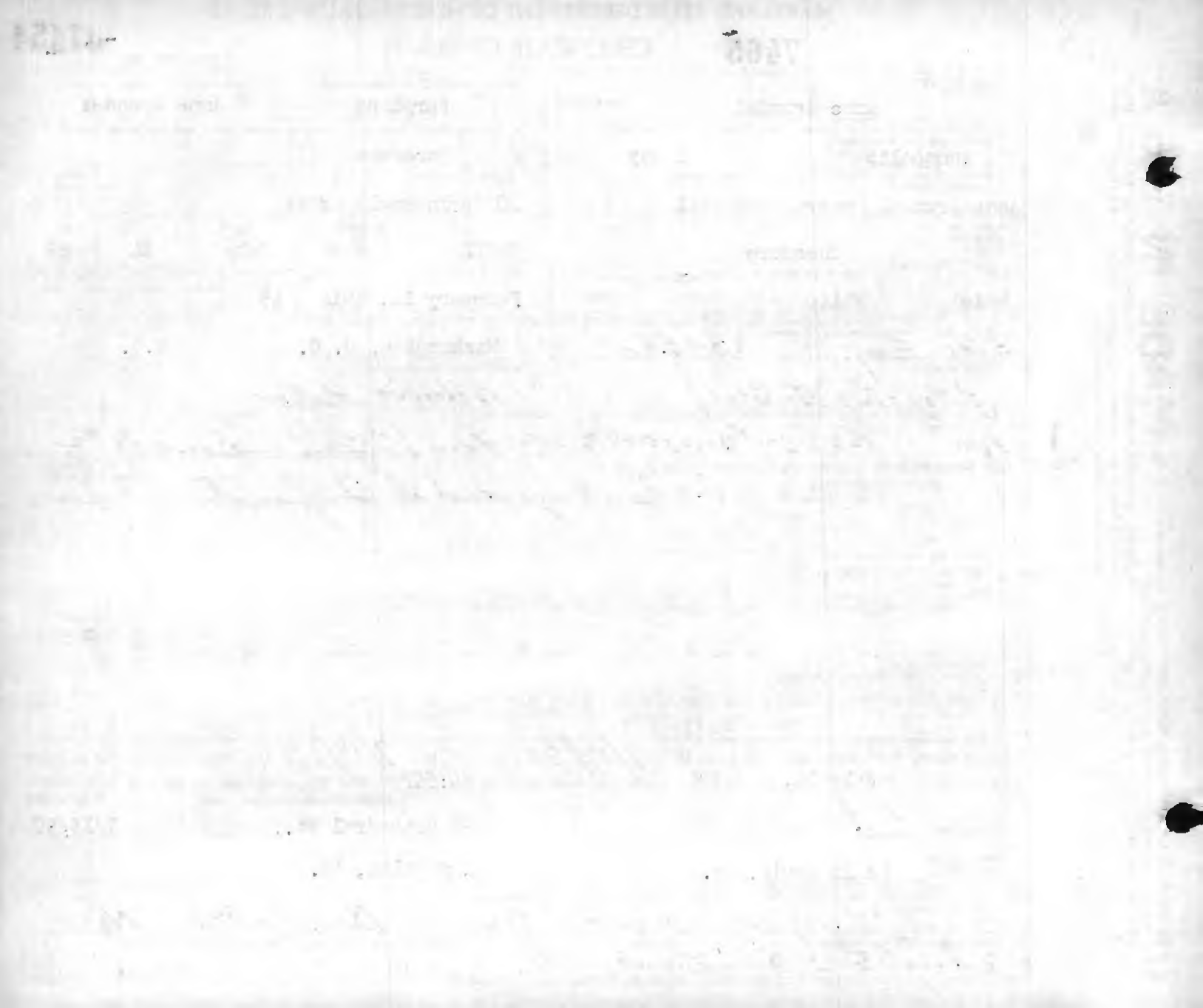
Reg. Dist. No.

-07454

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena			
				f. STREET ADDRESS 10 Springknoll Drive			
3. NAME OF DECEASED (Type or print) First Theodore Middle BEALL Last BEALL				4. DATE OF DEATH Month July Day 14 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 11, 1914	9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elec. Eng.		10b. KIND OF BUSINESS OR INDUSTRY G. & E. Co.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alexis J. Beall				14. MOTHER'S MAIDEN NAME Katherine Huller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-05-7776		INFORMANT Mrs. Anna V. Beall		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/14/59 , 19____, to 7/14/59 , 19____, that I last saw the deceased alive on July 14 , 19 59 , and that death occurred 4:55P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 98 Cathedral St., Annapolis, Md. DATE SIGNED 7/15/59							
ACTUAL SIGNATURE Edwin Davis, Jr.		PHYSICIAN'S NAME (Type) Edwin Davis, Jr. Annapolis, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 13, 1959		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Ceme		22d. LOCATION (City, town, or county) (State) Brooklyn RD Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Singleton - Glen Burnie, Md.				24a. REC'D BY REGISTRAR DATE JUL 20 '59		24b. REGISTRAR'S SIGNATURE Arthur J. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7500

CERTIFICATE OF DEATH

Reg. Dist. No. 07455

1 PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 3 years mo. 7 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 837 W. Lexington Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Hollie Bell		4. DATE OF DEATH Month Day Year 7 12 19 59	
5 SEX Female	6. COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/18/1913
9 AGE (in years last birthday) 45		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest Preston		14. MOTHER'S MAIDEN NAME Ellena Nichols	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia DUE TO 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Cervix DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Central Nervous System Syphilis 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----	
20c TIME OF INJURY Month, Day, Year Hour 4:45 p. m. 19 59	20d INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> black white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f (City or town) (County) (State) -----
21. I certify that I attended the deceased from 3/5 , 19 56 , to 7/12 , 19 59 , that I last saw the deceased alive on 7/12 , 19 59 , and that death occurred at 11:45 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 7/13/59			
ACTUAL SIGNATURE L. Benedict, M. D.		PHYSICIAN'S NAME (Type) Crownsville State Hospital, Md. 7/13/59	
22a BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
1-16-59	7/13/59	St. Ignace	Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kate H. McLean		ADDRESS 323	24a REC'D BY REGISTRAR DATE JUL 16 '59
		24b. REGISTRAR'S SIGNATURE Charles S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7466

CERTIFICATE OF DEATH

07456

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>York</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Visit</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>York</u>		d. STREET ADDRESS <u>5068 Pershing Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Weems Creek</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Shower</u> Last <u>Beltz Jr.</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 1, 1936</u>
9. AGE (In years last birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>USAF Band</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Harry Shower Beltz Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Florence Dick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1954-1959</u>		16. SOCIAL SECURITY NO <u>185-28-1726</u>	
17. INFORMANT <u>Official Air Force Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned while swimming</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>0030</u> a.m. <u>July 17</u> 19 <u>59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <u>at work</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Weems Creek</u>		20f. (City or town) (County) (State) <u>Annapolis</u> <u>Arundel</u> <u>Maryland</u>	
21. I certify that I attended the deceased from <u>NEVER</u> , 19 <u> </u> , to <u>NEVER</u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>0030A</u> M, from the causes and on the date stated above. <u>Reviewed remains upon arrival - See reverse</u>			
ACTUAL SIGNATURE <u>Heino Trees</u> M.D.		ADDRESS (Street, city or town, state) <u>USAF HOSPITAL ANDREWS</u> DATE SIGNED <u>17 Jul 59</u>	
PHYSICIAN'S NAME (Type) <u>HEINO TREES MD</u> <u>WASHINGTON 25, D. C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-22-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>York, Penna.</u>		22d. LOCATION (City, town, or county) (State) <u>York, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rinaldi Funeral Home Inc. 816-H ST NE</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 22 '59</u>	
ADDRESS <u>Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

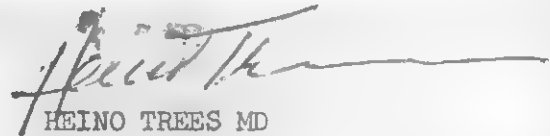
CERTIFICATE

I the undersigned, Emergency Doctor, USAF Hospital Andrews, affirm that the remains were received from US Naval Hospital Annapolis Maryland at 1300 hours 17 Jul 59.

The Coroner, Arundel County, released remains to service control and desired that the Death Certificate be prepared by service facility performing the autopsy.

Jurisdiction over remains was released to and accepted by USAF Hospital Andrews, Andrews AFB, Camp Springs, Prince Georges County, Maryland.

Cause of death confirmed by autopsy.


HEINO TREES MD
Emergency Doctor

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, on in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

7501

Items 3, 13 See note from funeral Dir. on back of Cert.

Reg. Dist. No.

07457

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN TB 12hrs. 15min.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		d. STREET ADDRESS 330 Cannon		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Merriitt Middle Berryman Last Berman		4. DATE OF DEATH Month 7 Day 2 Year 1959		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/13/06	
9. AGE (In years last birthday) yrs. 53		10. IF UNDER 1 YEAR Months 5		11. IF UNDER 24 HRS. Days 2		12. HOURS 19		13. MIN. 59		14. MIN. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Berman Berryman		14. MOTHER'S MAIDEN NAME Mary	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Yes.		INFORMANT Hospital Records		Address		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4110X Congestive Heart Failure DUE TO Chronic Mitral Stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Lobar Pneumonia		18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) -----		(State) -----	
21. I certify that I attended the deceased from 7/1/59 , 19 59 , to 7/2 , 19 59 , that I last saw the deceased alive on 7/2 , 19 59 , and that death occurred at 3:30 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 7/2/59		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/59		22c. NAME OF CEMETERY OR CREMATORY James Cemetery		22d. LOCATION (City, town, or county) (State) Near Chestertown, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Berneth Waller	
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Please note - Correct spelling for the deceased
last name is

BERRYMAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7502 **CERTIFICATE OF DEATH**

Reg. Dist. No.

07458

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 4 years 6mo. 29 days		2. USUAL RESIDENCE (Where deceased lived. If institution on residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 2227 Etting Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Sarah Edna Earl		First Middle Last Booker		4. DATE OF DEATH Month Day Year 7 7 19 59							
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1889		9. AGE (In years last birthday) yrs 70		10. IF UNDER 1 YEAR Months Days Hours Min	
11a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		11b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] Unknown		16. SOCIAL SECURITY NO Unknown		INFORMANT Hospital Records		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) Cerebro-Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----									
20c. TIME OF INJURY Month, Day, Year Hour 0:15 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) -----		(State) -----	
21. I certify that I attended the deceased from 12/8 , 19 54 , to 7/7 , 19 59 , that I last saw the deceased alive on 7/7 , 19 59 , and that death occurred at 6:28 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town state) Crownsville State Hospital, Md. DATE SIGNED 7/7/59											
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. L. Benedict, M. D.		Crownsville State Hospital, Md.		7/7/59					
PHYSICIAN'S NAME (Type)		22b. DATE THEREOF 7-10-59		22c. NAME OF CEMETERY OR CREMATORY St. Calvary		22d. LOCATION (City, town, or county) A Baltimore		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS 918 E. ...		24a. REC'D BY REGISTRAR DATE JUL 9 - '59		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07459

7467

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admn-ssion) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2051 Washington St.</u>		d. STREET ADDRESS <u>2051 Washington St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles E. Bowie</u>		4. DATE OF DEATH Month <u>07</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-20-1876</u>
9. AGE (In years last birthday) <u>73</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Calvert Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Augustus Bowie</u>		14. MOTHER'S MAIDEN NAME <u>Temple Randall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mamie F. Bowie - Annapolis, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Intestinal Obstruction</u> <u>561.0</u> DUE TO <u>Strangulated Left Inguinal Hernia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>24hrs</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/19/59</u> 19 <u>59</u> to <u>7/19/59</u> 19 <u>59</u> , that I last saw the deceased alive on <u>7/19/59</u> 19 <u>59</u> , and that death occurred at <u>2:40</u> P.M. from the causes and on the date stated above.			
REGISTRAR'S SIGNATURE <u>R. L. Chavira</u>		DATE SIGNED <u>110-C-1757</u>	
PHYSICIAN'S NAME (Type) <u>William Reese, Jr. - Annapolis, Md.</u>		ADDRESS	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-23-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fowlers</u>	22d. LOCATION (City, town, or county) (State) <u>Best Gate Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 21 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 7503 CERTIFICATE OF DEATH

Reg. Dist. No. 2707460

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade			c. LENGTH OF STAY IN 1b 8 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown			d. STREET ADDRESS 8622 Church Lane
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EMIL Middle JAMES Last BRANDON		4. DATE OF DEATH Month July Day 26 Year 19 59					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Oct 1892	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR: Months Days Hours Min	IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY New York		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Brandon				14. MOTHER'S MAIDEN NAME Corinne Alberta			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 116-12-3491		17. INFORMANT Son Address 8622 Church Lane Randallstown, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 26 July 19 59 to 26 July 19 59 , that I last saw the deceased alive on 26 July 19 59 , and that death occurred at 1135AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE ROGER C. MOYER, Capt, MC, U.S. Army Hospital, Ft. Meade, Md 26 Jul 59 PHYSICIAN'S NAME (Type) ROGER C. MOYER, Capt, MC, U.S. Army Hospital, Ft. George G. Meade, Md 26 Jul 59							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 7-27-59		22c. NAME OF CEMETERY OR CREMATORY Fresh Pond Crematory		22d. LOCATION (City, town, or county) (State) Maspeth, Long Island, New York	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE JUL 28 '59		24b. REGISTRAR'S SIGNATURE Arthur G. Knecht	

7468

CERTIFICATE OF DEATH

07461

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>The Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>Box 273-A Annapolis Neck Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Tyrone</u> Middle <u>Anthony</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 7, 1959</u>	
9. AGE (In years lost birthday) yrs <u>2</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Archie Curnell Brown</u>				14. MOTHER'S MAIDEN NAME <u>Helen Flontina Taylor</u>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>106-10-2734</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>76x</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u>July</u> Day <u>7</u> Year <u>19 59</u> Hour <u>a. m.</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 7, 19 59</u> to <u>July 8, 19 59</u> that I last saw the deceased alive on <u>July 8, 19 59</u> , and that death occurred at <u>12:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. R. Richardson</u>				M.D. <u>110 Clay St Annapolis</u> 7/9/59			
PHYSICIAN'S NAME (Type) <u>Dr. R. R. Richardson</u>				<u>Clay St. Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL. (Specify)		22b. DATE THEREOF <u>7-10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>				ADDRESS <u>17 Anna. Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7469

CERTIFICATE OF DEATH

07462

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>7 West Elliott Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Buser</u> Last <u>Buser</u>				4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 16, 1910</u>	
9. AGE (In years last birthday) <u>48</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STORE KEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERIES</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>HENRY BUSER</u>				14. MOTHER'S MAIDEN NAME <u>ELISE MOHLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Elizabeth S. Buser</u> (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Partial obstructive obstruction</u> DUE TO <u>(operated)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ast. (b) <u> </u> DUE TO <u> </u> (c) <u>Malignant Salivary Gland Tumor</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 mon</u> <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1955</u> to <u>7-9-1959</u> that I last saw the deceased alive on <u>7-9-59</u> , 19 <u> </u> , and that death occurred at <u>1:59 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M Shipley</u>				ADDRESS (Street, city or town, state) <u>121 Cathedral St Annapolis, Md</u>			
DATE SIGNED <u>7-10-59</u>							
PHYSICIAN'S NAME (Type) <u>Frank M Shipley</u>				<u>Annapolis, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Scyler Suss</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 13 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7504

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Laurel, Md.		c. LENGTH OF STAY IN 1b 1 yr. 4 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION District Training School, Children's Center				d. STREET ADDRESS 1322 - 11th St. N.W., Apt. 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marian Middle Elaine Last Byrd				4. DATE OF DEATH Month July Day 1 Year 1959			
5. SEX female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/16/54	
9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min 59		IF UNDER 24 HRS Months 4 Days 1 Hours 1 Min 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Walter Edward Byrd				14. MOTHER'S MAIDEN NAME Barbara E. Law			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) ---				16. SOCIAL SECURITY NO. ---		17. INFORMANT Children's Center, Laurel, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia - partial atelectasis - lft. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral palsy - rigidity quadriplegia DUE TO (c) mental retardation - severe							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
20f. (City or town) (County) (State) ---							
21. I certify that I attended the deceased from February 28, 1958 , to July 1, 1959 , that I last saw the deceased alive on July 1, 1959 , and that death occurred at 10:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Children's Center, Laurel, Md. DATE SIGNED 7/1/59							
ACTUAL SIGNATURE Wilfred R. Ehrmantraut, M.D.							
PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) 7-6-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Lincoln Mem.		22d. LOCATION (City, town, or county) (State) Frederick Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A M DROSE B. Boyd				ADDRESS 1238 - 26 St NW		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
				24b. REGISTRAR'S SIGNATURE Cuthbert & Thomas			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7505 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07464

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Meade</u>		c. LENGTH OF STAY IN 1b <u>One hour</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Gardens, Glen Burnie</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Building #4554</u>				/d. STREET ADDRESS <u>99 Glen Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jesse J. Cassady</u> First Middle Last				4. DATE OF DEATH Month Day Year <u>July 15th.</u> 19 <u>59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/9/96</u>		9. AGE (In years last birthday) <u>62</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>		11. BIRTHPLACE (State or foreign country) <u>Blackburg, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James W. Cassady</u>				14. MOTHER'S MAIDEN NAME <u>Magdalena Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>World War I</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Elvie Effinger Cassady</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Blackburg, Virginia</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>7/15/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>18 July '59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westview Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Blackburg, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard W. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur B. Kraus</u>	
				24b. REGISTRAR'S SIGNATURE			

7470

CERTIFICATE OF DEATH

Reg. Dist. No.

07465

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 608 Arlington Village	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nellie Middle COLEMAN Last COLEMAN		4. DATE OF DEATH Month July Day 7 Year 19 59	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1885
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Corbett		14. MOTHER'S MAIDEN NAME Celestine Curran	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		18. INFORMANT Robert C. Adams Address 407 Lakeview Ave., Mayo, N.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 493X DUE TO (c) 493X		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic mellitus, Cerebral vascular accident		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/6 , 19 59 , to 7/7/59 , 19 59 , that I last saw the deceased alive on 7/7/59 , 19 59 , and that death occurred at 7:45 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 121 Cathedral St., Annapolis, Md.	
ACTUAL SIGNATURE Richard N. Peeler		DATE SIGNED 7/7/59	
PHYSICIAN'S NAME (Type) Richard N. Peeler		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 10, 1959		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert X. Murphy		24a. REC'D BY REGISTRAR JUL 10 '59	
ADDRESS 3524 Columbia Pike, Arlington, Va.		24b. REGISTRAR'S SIGNATURE Arthur S. Kram	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7471

CERTIFICATE OF DEATH

07466

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>13</u> Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>			d. STREET ADDRESS <u>107 Clay Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Lewis CROCKER</u>			4. DATE OF DEATH Month Day Year <u>July 24 19 59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-30-01</u>	9. AGE (In years last birthday) <u>58</u> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>	
13. FATHER'S NAME <u>Rev. Thomas Lewis CROCKER</u>			14. MOTHER'S MAIDEN NAME <u>Belle Rainy Scott</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>WW II</u>		17. INFORMANT <u>U.S. Naval Hospital, Annapolis Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X INTRA-CEREBRAL HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>10 1/2</u> hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>7-24</u> , 19 <u>59</u> , to <u>7-24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-24</u> , 19 <u>59</u> , and that death occurred at <u>6:20 P</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>R. I. HOCHMAN</u> M.D. <u>US Naval Hospital, Annapolis, Md.</u> DATE SIGNED <u>7-25-59</u> PHYSICIAN'S NAME (Type) <u>R. I. HOCHMAN LCDR MC USN</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<u>burial</u>		<u>7-29-59</u>		<u>Annapolis Natl. Cemetery, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Leese, Jr.</u>		ADDRESS <u>107 Clay Street</u>		24a. REC'D BY REGISTRAR DATE <u>UL 27 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knead</u>	

7472

CERTIFICATE OF DEATH

Reg. Dist. No. 07467

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 4 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Severn				d. STREET ADDRESS Rt-1, Box-230			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle H. Last CROUSE, Sr.				4. DATE OF DEATH Month July Day 28 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH January 18, 1892	
9. AGE (In years lost birthday) 67 yrs		IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. 67		IF UNDER 24 HRS. Months 67 Days 67 Hours 67 Min. 67			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JAMES H. CROUSE				14. MOTHER'S MAIDEN NAME ANNA M. CROUSE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gen. Carcinomatosis - primary 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) not unknown DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 yrs.				INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 24, 1959 , to July 28, 1959 , that I lost saw the deceased alive on July 28, 1959 , and that death occurred at 8:45 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Amos Garrett Blvd., Annapolis, Md. DATE SIGNED 7/29/59							
ACTUAL SIGNATURE Samuel Borssuck				M.D. Amos Garrett Blvd., Annapolis, Md.			
PHYSICIAN'S NAME (Type) Samuel Borssuck							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/1/59		22c. NAME OF CEMETERY OR CREMATORY Baldwin Memorial		22d. LOCATION (City, town, or county) (State) Milkersville, AA, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & KIRKLEY				24a. REC'D BY REGISTRAR DATE JUL 31 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL (If attending physician: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7506

CERTIFICATE OF DEATH

07468

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 340.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Nursing Home</u>		d. STREET ADDRESS <u>2219 N. Howard</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Davis</u>		4. DATE OF DEATH <u>July 1</u> 19 <u>59</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-2-1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Ethel Johnson Davis</u>		Address <u>2219 N. Howard</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heat stroke.</u> <u>445X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I attended the deceased from <u>2-28</u> , 19 <u>59</u> , to <u>6-28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-28</u> , 19 <u>59</u> , and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John P. ...</u> M.D.		ADDRESS (Street, city or town, state) <u>P.O. Box 37</u> DATE SIGNED <u>7/1/59</u>	
PHYSICIAN'S NAME (Type) <u>John P. ...</u>		<u>Odessa Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/6/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holstein-March</u> ADDRESS <u>918 Druid Hill Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 7 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>

7473

CERTIFICATE OF DEATH

Reg. Dist. No. 07469

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>x East Port</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>		d. STREET ADDRESS <u>306 Chester Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Davis</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-1904</u>
9. AGE (In years last birthday) <u>54</u> yrs		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>9</u> Min <u>9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Customer Tavern</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>	
11. BIRTHPLACE (State or foreign country) <u>A. A. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Vermont Brown</u>		14. MOTHER'S MAIDEN NAME <u>Alice Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Informant</u> <u>George Davis East Port</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>7 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>2 PM 7/25, 1959</u> to <u>2 PM 7/25, 1959</u> , that I last saw the deceased alive on <u>7/25, 1959</u> , and that death occurred at <u>2 PM</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Hedeman</u>		ADDRESS (Street, city or town, state) <u>121 Cathedral St.</u> DATE SIGNED <u>7/25/59</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7-28-59</u>	<u>Annapolis Neck</u>	<u>Annapolis, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Geese, Jr. - Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 27 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7474

CERTIFICATE OF DEATH

07470

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Res. dence before admission) a. STATE <u>VA.</u> b. COUNTY <u>Mecklenburg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE-ARUNDEL GEN. Hosp.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>FANNIE ELIZABETH DAVIS</u>		4. DATE OF DEATH <u>JULY 5 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3-1885</u>
9. AGE (In years last birthday) <u>73</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Never Worked</u>	
11. BIRTHPLACE (State or foreign country) <u>Chase-City VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A</u>	
13. FATHER'S NAME <u>Charles W. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Puryear</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Dr. HARVEY F. DAVIS-Rt. 3-Box 181A.</u>		Address <u>ANNA, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO <u>Hypertensive Cardiac-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Nephrosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/30 1959</u> , to <u>7/5 1959</u> , that I last saw the deceased alive on <u>7/5 1959</u> , and that death occurred at <u>12:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore L. Johnson</u> M.D.		ADDRESS (Street, city or town, state) <u>37 Calvert Street Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>DR. THEODORE L. JOHNSON</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-9-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethlehem</u>	22d. LOCATION (City, town, or county) (State) <u>Chase City VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks</u> ADDRESS <u>ANNAPOLIS-Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 10 '59</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7475

CERTIFICATE OF DEATH

07471

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 704 Wells St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Irene Middle DAVIS Last DAVIS				4. DATE OF DEATH Month July Day 28 Year 1959			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-29-1882	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 7 Days 0 Hours 0 Min 0		11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME David Dorsey				14. MOTHER'S MAIDEN NAME Mary Dorsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO INFORMANT Jda Stollard - Anna. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Coma & Pulmonary DUE TO is demand for Central Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (Anterior) Diabetic (by pulmonary disease) DUE TO (c) (Anterior) Diabetic (by pulmonary disease)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 22, 1959 , to July 28, 1959 , that I last saw the deceased alive on July 28, 1959 , and that death occurred at 7:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 110 Clay St., DATE SIGNED 7/29/59							
ACTUAL SIGNATURE R. L. Richardson				PHYSICIAN'S NAME (Type) R. L. Richardson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-31-59		22c. NAME OF CEMETERY OR CREMATORY Centerville	
23. FUNERAL DIRECTOR'S SIGNATURE William Leese, Jr. - Anna. Md.				24a. REC'D BY REGISTRAR DATE JUL 30 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO REGISTER: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

7476

CERTIFICATE OF DEATH

Reg. Dist. No. 07472

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 1808 Lincoln Drive	
3. NAME OF DECEASED (Type or print) First Sherman Middle DORSEY Last DORSEY		4. DATE OF DEATH Month July Day 19 Year 1959	
5 SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-1905
9 AGE (In years last birthday) 54 yrs		10. IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min 54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James G. Dorsey		14. MOTHER'S MAIDEN NAME Mary Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. May 20, 1905; 1808 Lincoln Dr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the prostate with metastases to Pelvic & Pericardial lymph nodes DUE TO (b) and bones of Pelvis & spine DUE TO (c) Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 14th , 19 59 , to July 19th , 19 59 , that I last saw the deceased alive on July 14th , 19 59 , and that death occurred at 9:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 110 Clay St., Annapolis, Md.	
ACTUAL SIGNATURE R. L. Richardson		DATE SIGNED 7/19/59	
PHYSICIAN'S NAME (Type) R. L. Richardson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-23-1959	
22c. NAME OF CEMETERY OR CREMATORY Centers Methodist		22d. LOCATION (City, town, or county) (State) Anne Arundel Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. H. 108 Washington Ave. Md		24a. REC'D BY REGISTRAR BUL 21 '59	
24b. REGISTRAR'S SIGNATURE Robert S. Thomas			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7507

CERTIFICATE OF DEATH

08647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Drury		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION --		d. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) First MARY Middle Emily Last DRURY		4. DATE OF DEATH Month July Day 9 Year 1959	
5 SEX Female	6. COLOR OF RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1870
9. AGE (In years, months, days, hours, minutes) 89 yrs 9 months 9 days 11 hours 15 min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolteacher	
10b. KIND OF BUSINESS OR INDUSTRY Public Schools		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY U. S. A.		13. FATHER'S NAME James O. Drury, Sr.	
14. MOTHER'S MAIDEN NAME Elizabeth Mayhew		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO --		17. INFORMANT Mr. James O. Drury, Jr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized, severe DUE TO (b) 450.0 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) 5 yrs		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 4 , 19 46 , to July 9 , 19 59 ; that I last saw the deceased alive on 6 July , 19 59 ; and that death occurred at 11:20 P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Upper Marlboro, Maryland DATE SIGNED 7/9/59			
ACTUAL SIGNATURE R. B. Sasscer M.D.			
PHYSICIAN'S NAME (Type) R. B. Sasscer, M.D.			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/11/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State) Upper Marlboro Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		24a. REC'D BY REGISTRAR DATE AUG 11 '59	24b. REGISTRAR'S SIGNATURE Charles S. Kline

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7508

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
Items 8, 14, 11, 12, 4b 7-31-59 et
CERTIFICATE OF DEATH

07473

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 Brookfield Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LENA</u> First Middle Last <u>ELLISON</u>		4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1885</u> <u>Oct. 18, 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William B. Stinchcomb</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Mrs Nellie Stallings, same as 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>SENILITY</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 YEARS</u> <u>20 YEARS</u> <u>15 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JULY 23, 1959</u> , to <u>—</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>—</u> , 19 <u>—</u> , and that death occurred at <u>12:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u> M.D. <u>Mountain Road</u>		DATE SIGNED <u>7-23-59</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR M.D</u> <u>Pasadena, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>7/26/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>	22d. LOCATION (City, town, or county) (State) <u>Pasadena, AA, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley, Glen Burnie, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUL 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is missing, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7509

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07474

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park		c. LENGTH OF STAY IN IN 7 Years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 220 E. 25th, st.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Mrs. S. Elizabeth Fisher		4. DATE OF DEATH Month Day Year July 12th. 19 59		5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/16/05		9. AGE (in years last b'irthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Arthur C. Adams		14. MOTHER'S MAIDEN NAME Helen Bueschel		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. John L. Fisher (Husband)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		ACTUAL SIGNATURE Gustave H. Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7/12/59		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15-59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gustave H. Faubert		ADDRESS 2224 N. Charles		24a. REC'D BY REGISTRAR JUL 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7510

CERTIFICATE OF DEATH

07475

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>AA.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old Annapolis Rd.</u>				d. STREET ADDRESS <u>Old Annapolis</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>W.</u> Last <u>FORD.</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>A</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-10-83</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR: Months Days Hours		IF UNDER 24 HRS: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>C.S. CB.</u>		11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CLARK</u>				14. MOTHER'S MAIDEN NAME <u>CLARK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Family - James</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, } (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 HOURS</u> <u>2 YRS.</u> <u>5 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL ARTERIOSCLEROSIS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY 25</u> , 19 <u>59</u> , to <u>JULY 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JULY 29</u> , 19 <u>59</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u>				ADDRESS (Street, city or town, state) <u>Mountain Rd. Pasadena Maryland</u>		DATE SIGNED <u>7-30-59</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR.</u>				<u>Pasadena Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home</u>				ADDRESS <u>1200 E. To L. Cir.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 4 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Lankford</u>							

7477

CERTIFICATE OF DEATH

Reg. Dist. No. 07476

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11 Severn Ave</u>		d. STREET ADDRESS <u>11 Severn Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Bright</u> Last <u>Francis</u>		4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar-29-1890</u>
9. AGE (In years lost birthday) yrs. <u>69</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Bright</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Custer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>7 Mrs. Sh. Caraway</u>	
17. INFORMANT <u>Mrs. Sh. Caraway</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Paralysis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Stroke</u> DUE TO (c) <u>Heart</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 18, 1959</u> to <u>July 18, 1959</u> , that I last saw the deceased alive on <u>July 18, 1959</u> , and that death occurred at <u>11, from the causes and on the date stated above.</u> ADDRESS (street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>E. H. [Signature]</u> M.D.		PHYSICIAN'S NAME (Type) <u>E. H. [Signature]</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 18-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u>		ADDRESS <u>Annapolis Md.</u>	24a. REC'D BY REGISTRAR DATE <u>JUL 20 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item 20 FilmG244 7511					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					Reg. Dist. No. 07477	
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A. A.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXXXXX Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Earleigh Hgts. Rd. S. of Ritchie Hgwy.					d. STREET ADDRESS Hamburg and Light Streets					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) First Middle Last ALBERT MARION FRIEND					4. DATE OF DEATH Month Day Year July 1 19 59						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 14, 1889		9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Friend					14. MOTHER'S MAIDEN NAME Julia Hampton						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs Marian Snoberger, same as 2						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>812X</u> <u>Exsanguination due to severed femoral artery</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>812X</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by auto								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. ? 19			20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Pasadena (County) A. A. (State) Md.				
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Notatural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Charles S. Petty</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/1/59				
EXAMINER'S NAME (Type) Charles S. Petty, M.D.					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 7/3/59		22c. NAME OF CEMETERY OR CREMATORY Glen Haven			22d. LOCATION (City, town, or county) (State) Glen Burnie, Md			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & KIRKLEY</u>					ADDRESS Glen Burnie		24a. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE <u>Carlton L. Kiser</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1x20 Film 246 3-12-51

07478

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ft George G. Meade	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JERRY Middle L. Last GARMON		4. DATE OF DEATH Month 15 Day July Year 19 59	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Oct 1936
9. AGE (In years last birthday) yrs 22		10. IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min. 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Donald Laverne Garmon		14. MOTHER'S MAIDEN NAME Marion Rachiel (last name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) entered 4 Feb 54		16. SOCIAL SECURITY NO. 490-44-9944	
17. INFORMANT Military Records NSA, Ft Meade, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gunshot Wounds of Abdomen DUE TO (c) 4 hrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Gunshot -- Homicide	
20c. TIME OF INJURY Month, Day, Year Hour 0245 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Waterloo Md		20f. (City or town) (County) (State) Waterloo Anne Arundel Md	
21. I certify that I attended the deceased from 15 July 19 59 to 15 July 19 59 , that I last saw the deceased alive on 15 July 19 59 , and that death occurred at 0645 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard Bob Mass, Capt. MC		DATE SIGNED 15 Jul 59	
PHYSICIAN'S NAME (Type) HOWARD BOB MASS, Capt, MC		U.S. Army Hospital, Ft Meade, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 7/16/59	22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove	22d. LOCATION (City, town, or county) (State) Gorin, Mo.
23. FUNERAL DIRECTOR'S SIGNATURE Im. Cook, Inc., 1217 St. Paul St., Balto., Md.		24a. REC'D BY REGISTRAR JUL 20 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Knecht	

7513

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 1514 N. Fulton Ave.	
3 NAME OF DECEASED (Type or print) First Mabel Middle Goodman Last		4. DATE OF DEATH Month July Day 3 Year 1959	
5 SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 1905
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic worker		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME John Henry Baker		14 MOTHER'S MAIDEN NAME Bertha	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Medical Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 4222 DUE TO Fatty degeneration of myocardium Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a m p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/16 , 19 58 , to 7/3 , 19 59 that I last saw the deceased alive on 7/3 , 19 59 , and that death occurred at 6:08 PM , from the causes and on the date stated above			
ACTUAL SIGNATURE M. Benedict		ADDRESS (Street, city or town, state) Crownsville, Md.	
PHYSICIAN'S NAME (Type) Dr. Ludwig Benedict		DATE SIGNED 7/15/59	
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		22d LOCATION (City, town, or county) (State) Anne Arundel County MD	
23 FUNERAL DIRECTOR'S SIGNATURE G. H. [Signature]		ADDRESS 918 Druid Hill Ave.	
24a REC'D BY REGISTRAR AUG 7 '59		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7514

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		e. STREET ADDRESS <u>Rt. 1, Box 110</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>D.</u> Last <u>Gutrick</u>		4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1959</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-7-82</u>
9 AGE (In years last birthday) <u>76?</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Government Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- -</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>- -</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive & Arteriosclerotic Cardiovascular</u> DUE TO <u>Renal disease & Cardiomegaly.</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>- - - - -</u>	
20c. TIME OF INJURY Month, Day, Year Hour o m. <u>- -</u> p. m. <u>- -</u> 19 <u>- -</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>- - - - -</u>		20f. (City or town) (County) (State) <u>- - - - -</u>	
21. I certify that I attended the deceased from <u>5/4</u> 19 <u>59</u> to <u>7/30</u> 19 <u>59</u> that I last saw the deceased alive on <u>7/30</u> 19 <u>59</u> and that death occurred at <u>11:25 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hosp., Md.</u> DATE SIGNED <u>7/31/59</u>			
ACTUAL SIGNATURE <u>Lionel McHenry Mapp, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-5-59 Zion Baptist</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Hill Top, Chas. Co. Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Montgomery Bldg. 913 The Avenue</u>		24a. REC'D BY REGISTRAR DATE <u>54</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Pinner</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7515

CERTIFICATE OF DEATH

07480
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Thomas Last Hall				4. DATE OF DEATH Month 7 Day 14 Year 1959			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/22/13	
9. AGE (In years last birthday) 45 yrs		10. IF UNDER 1 YEAR Months 3 Days 14		11. IF UNDER 24 HRS. Hours 14 Min. 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ehauseur				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Tate Hall				14. MOTHER'S MAIDEN NAME Helen Roberta Stewart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		INFORMANT Address Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia							
DUE TO Nephrotic Syndrome							
DUE TO Hypertensive Cardiovascular Renal Disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from 8/22 , 19 57 , to 7/14 , 19 59 , that I last saw the deceased alive on 7/14 , 19 59 , and that death occurred at 6:45 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp				ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.			
DATE SIGNED 7/14/59							
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.				Crownsville State Hospital, Md. 7/14/59			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		July 18, 1959		Mount Calvary		Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Calvary C. Udon				ADDRESS 2004 Baltimore Md		24a. REC'D BY REGISTRAR DATE JUL 16 1959	
						24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7516 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08655

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 25</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5920 Bellegrove Rd.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <u>Gertie Hall</u>		4. DATE OF DEATH Month <u>July</u> Day <u>23rd</u> Year <u>19 59</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>?</u>		9. AGE (In years last birthday) <u>75 ?</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (domestic)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>				11. BIRTHPLACE (State or foreign country) <u>?</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>?</u>						14. MOTHER'S MAIDEN NAME <u>?</u>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>?</u>		17. INFORMANT <u>Mrs. Edith Howard (same address as deceased)</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>General asthenia</u> [c], stating the underlying cause lost. DUE TO <u>?</u>												INTERVAL BETWEEN ONSET AND DEATH <u>?</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)																	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m. Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.												CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED							
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>												ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7/23/59</u>							
22a. BURIAL (CREMATION REMOVAL SPECIFY)				22b. DATE THEREOF <u>8-25-59</u>				22c. NAME OF CEMETERY OR CREMATORY <u>W. M. School</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE												24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
ADDRESS												DATE <u>AUG 27 '59</u>		<u>W. M. School</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7478

CERTIFICATE OF DEATH

Reg. Dist. No.

07481

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2017 Forest Drive</u>		d. STREET ADDRESS <u>12017 Forest Drive</u>	
3 NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>Hall</u> Last <u>Hall</u>		4. DATE OF DEATH Month <u>7</u> Day <u>10</u> Year <u>1959</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-1882</u>
9. AGE (In years last birthday) yrs. <u>77</u>		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred Jennings</u>		14. MOTHER'S MAIDEN NAME <u>Martha Bailey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Joseph Jennings Anna, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO <u>Arteriosclerotic heart disease</u> (c) <u>Coronary artery disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 10, 1959</u> to <u>July 19, 1959</u> , that I last saw the deceased alive on <u>July 10, 1959</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ruth Richardson</u>		DATE SIGNED <u>7/13/59</u>	
PHYSICIAN'S NAME (Type) <u>William Reese, Jr.</u>		ADDRESS <u>110-CLAY ST. ANNAPOLIS, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-14-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cleaves Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Greenville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>		24a. REC'D BY REGISTRAR <u>JUL 14 '59</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7517
CERTIFICATE OF DEATH

Reg. Dist. No. **07482**

1. PLACE OF DEATH a. COUNTY AA MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedarhurst, Shadyside c. LENGTH OF STAY IN 1b 5 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY AA x c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedarhurst, Shadyside, M.D. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) MAUDE JESSE HARR First Middle Last				4. DATE OF DEATH July 6 19 59 Month Day Year											
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/28/85		9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 6 Days 8		11. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Hundred, W. Va.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James M. McCullough						14. MOTHER'S MAIDEN NAME ELIZABETH DAVIS									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes name unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Lillian M. Fitzhugh, Shadyside Md. Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon (adenocarcinoma) 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 1 year +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 1, 19 59 , to July 6, 19 59 , that I last saw the deceased alive on July 4, 19 59 , and that death occurred at 3 P. M. from the causes and on the date stated above.															
ACTUAL SIGNATURE Willard F. Smith M.D.						ADDRESS (Street, city or town, state) Shadyside, Md.						DATE SIGNED 7/6/59			
PHYSICIAN'S NAME (Type) WILLARD F. SMITH, MD															
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried				22b. DATE THEREOF 7/10/59				22c. NAME OF CEMETERY OR CREMATORY WOODLAWN				22d. LOCATION (City, town, or county) (State) FAIRMOUNT W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Bernard A. Galt, Salisville, Md.						24a. REC'D BY REGISTRAR						24b. REGISTRAR'S SIGNATURE Orlino S. Kline			
ADDRESS						DATE JUL 14 '59									

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7518 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 8,9 File 6245 8-14-59 et
CERTIFICATE OF DEATH

07483

Reg. Dist. No

1 PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Balto-city</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		c. LENGTH OF STAY IN 1b <i>2 1/2 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Crownsville State Hosp.</i>		e. STREET ADDRESS <i>101 N. Bond Street.</i>	
3. NAME OF DECEASED (Type or print) First <i>Hertie</i> Middle <i>Harris</i> Last <i>Harris</i>		4. DATE OF DEATH Month <i>7</i> Day <i>12</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>C.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/19/08</i> 1904? <i>59</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Harris</i>		14. MOTHER'S MAIDEN NAME <i>Nellie</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>none</i>		16. SOCIAL SECURITY NO <i>none</i>	
INFORMANT <i>Hospital records</i>		Address <i>Crownsville</i>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hypoxia</i> <i>4341</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>congestive heart failure.</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>PSYCHOTIC REACTION - CATATONIC TYPE</i>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/6</i> , 19 <i>55</i> to <i>7/25</i> , 19 <i>59</i> that I last saw the deceased alive on <i>7/25/59</i> , 19 <i>59</i> , and that death occurred at <i>3:45</i> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>K. Benedict M.D.</i>		ADDRESS (Street, city or town, state) <i>Crownsville State Hospital</i>	
PHYSICIAN'S NAME (Type) <i>L. Benedict M.D.</i>		DATE SIGNED <i>Crownsville, Md.</i>	
22a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b DATE THEREOF <i>7/28/59</i>	
22c NAME OF CEMETERY OR CREMATORY <i>MT. CALVARY Cem.</i>		22d LOCATION (City, town, or county) (State) <i>Cedar Hill, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. O. Wilson</i>		ADDRESS <i>1000 Brantley Ave.</i>	
24a REC'D BY REGISTRAR DATE <i>AUG 5 '59</i>		24b REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7519 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07484

Reg. Dist No.

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fair Haven</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Drwood</u> d. STREET ADDRESS e. IS RES. DEF. 1 ON A FIRM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Charles Herbert Johnson</u> First Middle Last 5. SEX <u>male</u> 6. COLOR OR RACE <u>Col.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>2-9-1942</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) <u>17</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>C. Moser</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Beverly Beach Maryland</u> 11. BIRTHPLACE (State or foreign country) <u>21. S. A.</u> 12. CITIZEN OF WHAT COUNTRY?		4 DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1959</u> 13. FATHER'S NAME <u>Herbert Johnson</u> 14. MOTHER'S MAIDEN NAME <u>Josephine Franklin</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>no</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>Josephine Mackell - Maryland, Md.</u> 17. INFORMANT <u>Josephine Mackell</u> Address <u>7519</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>929.8</u> DUE TO <u>Rowing</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rowing</u> DUE TO (c) <u>Rowing</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part II of item 18.) <u>Rowing</u>	
20c. TIME OF INJURY Month <u>7</u> Day <u>30</u> Year <u>1959</u> Hour <u>2:30</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.) <u>Rowing</u> 20f. (City or town) <u>Rowing</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles Herbert Johnson</u> EXAMINER'S NAME (Type) <u>Charles Herbert Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>8-1-59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Moses</u> 22d. LOCATION (City, town, or county) <u>Brewers, Md.</u> (State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u> ADDRESS 24a. REC'D BY REGISTRAR <u>7519</u> DATE <u>AUG 3 '59</u> 24b. REGISTRAR'S SIGNATURE <u>William Reese</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is required, the certificate should be executed within 72 hours after death. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7479

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Wesley Last JONES				4. DATE OF DEATH Month July Day 21 Year 19 59			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 30, 1907	
9. AGE (In years lost birthday) yrs. 51		10. IF UNDER 1 YEAR Months 51 Days 51 Hours 51 Min. 51		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Corps				10b. KIND OF BUSINESS OR INDUSTRY St. Rd. Comm.			
13. FATHER'S NAME Isiah Jones				14. MOTHER'S MAIDEN NAME Bertha Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-16-5914			
17. INFORMANT Frene Brown				Address Davidsonville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebellar and Pontine Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Vascular Disease DUE TO (c) 10 days				INTERVAL BETWEEN ONSET AND DEATH 10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left lower lobe pneumonia				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month 19 Day 19 Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 11, 1959 to July 20, 1959 , that I lost saw the deceased alive on July 20, 1959 , and that death occurred at 3:42A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 110 Clay St., DATE SIGNED 7/21/59							
ACTUAL SIGNATURE R. L. Richardson				M.D. 110 Clay St.,			
PHYSICIAN'S NAME (Type) R. L. Richardson				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7-24-59		Chever Memorial		Crownsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr.				ADDRESS 12 Anna, Md.			
24a. REG. BY REGISTRAR JUL 22 59				24b. REGISTRAR'S SIGNATURE Charles E. Huns			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7520

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVA				c. LENGTH OF STAY IN 1b 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RIVA GUEST HOUSE				d. STREET ADDRESS 1131 Tyler Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First NELLIE Middle I Last KNADLER				4. DATE OF DEATH Month July Day 26 Year 1959			
5 SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1885	
9. AGE (In years last birthday) 74 yrs.		F UNDER 1 YEAR IF UNDER 24 HRS Months 74 Days 74 Hours 74 Min 74					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) N Y C	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Phillip Phelps				14. MOTHER'S MAIDEN NAME Regina (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No no				16. SOCIAL SECURITY NO. 220-09-9577			
INFORMANT Mrs Wilbur H. McNew Sr. - Daughter				Address 742 Warren Dr Annapolis, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypostatic pneumonia 502X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cema DUE TO (c) Multiple cerebrovascular thromboses INTERVAL BETWEEN ONSET AND DEATH 3 days 4 day 7 yr							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1955 to July 1959 , that I last saw the deceased alive on June 23, 1959 , and that death occurred at 1:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 121 Cathedral DATE SIGNED 7/27/59							
ACTUAL SIGNATURE John L Hedeman				M.D. Annapolis Md			
PHYSICIAN'S NAME (Type) John Hedeman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 29, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR DATE JUL 29 59	
24b. REGISTRAR'S SIGNATURE Calvin S. Farnell							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7521

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07487

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riviera Beach</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8483 Ft. Smallwood Rd.</u>		d. STREET ADDRESS <u>23 Terrace Road</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>J</u> Middle <u>KRALL</u> Last		4. DATE OF DEATH <u>JULY</u> Month <u>9</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/1/1904</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Catherine McCullough Krall, wife, above</u>	
17. INFORMANT <u>Catherine McCullough Krall, wife, above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CORONARY INSUFFICIENCY</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Mountain Rd</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Arthur Lankford Jr</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR MD</u> <u>Pasadena, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/13/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schimunek</u> <u>3331 Abrams Lane</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7523

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07488

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pt. Pleasant</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jct. Staterts. 177 and 648</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>T</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 11, 1894</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Isaac Martin</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Philip Rosenberg, 610 Washington Blvd</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple traumatic injuries</u> <u>12X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by auto while walking.</u>	
20c. TIME OF INJURY Hour <u>2:25</u> a. m. <u> </u> Month, Day, Year <u>July 4, 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Pasadena Anne Arundel Maryland</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charles S. Petty</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles S. Petty</u>		7/4/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-15-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 16 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

7522

CERTIFICATE OF DEATH

07489

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater Md</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Beach</u> Last <u>McBride</u>		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 19, 1900</u>
9. AGE (In years for birthday) <u>59</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary U.S. Government</u>	11. BIRTHPLACE (State or foreign country) <u>Iowa</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Charles B. Mather</u>	
14. MOTHER'S MAIDEN NAME <u>Maudie Stephens</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Antia M Smith, Edgewater Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary to cancer of left breast</u> DUE TO (c) <u>4 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>July 5, 1959</u> , to <u>July 31, 1959</u> , that I last saw the deceased alive on <u>July 31, 1959</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.	
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Sylvia M. Lim</u> M.D.		<u>RFD #1, Box 277-M 7/31/59</u>	
PHYSICIAN'S NAME (Type) <u>Sylvia M. Lim</u>		<u>Edgewater, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 3, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gaschs Sons</u> ADDRESS <u>Hyattsville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Rouse</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3. The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7524

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mayo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mayo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Edgewater P.O.</i>		d. STREET ADDRESS <i>Edgewater P.O.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Emma</i> First <i>Lacey</i> Middle <i>McCarter</i> Last		4. DATE OF DEATH Month <i>JULY</i> Day <i>6</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-12-1881</i>
9. AGE (In years last birthday) <i>77</i> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>aa Co Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>James Francis Stullings</i>		14. MOTHER'S MAIDEN NAME <i>Emma Harriett Wheeler</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>James E. McCarter</i> Address <i>143 Spa. Viewline Annapolis Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic hypertensive -</i> DUE TO <i>Cardiovascular disease</i> (c)			INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs.</i> <i>7 years</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec. 27, 1959</i> to <i>July 3, 1959</i> , that I last saw the deceased alive on <i>July 3, 1959</i> , and that death occurred at <i>5:07 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Sylvia M. Linn</i> M.D. <i>RFD #1 Box 272-M</i> <i>7/6/59</i> PHYSICIAN'S NAME (Type) <i>Sylvia M. Linn</i> <i>Edgewater, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>7-8-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>MAYO MEN CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>MAYO MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>JOHN M. TAYLOR SONS ANNAPOLIS MD.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 8 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur E. H.</i>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7480

Item 9 Filed 246 8-3-59 et

CERTIFICATE OF DEATH

07491

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>53 Lafayette Ave.,</u>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>H</u> Last <u>MORGAN</u>		4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 21 1873</u>
9. AGE (In years last birthday) <u>85</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>18</u> Days <u>85</u> Hours <u>18</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miss Salesman Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant</u>	
11. BIRTHPLACE (State or foreign country) <u>Winsted Conn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James P. Morgan</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Informant</u>	
17. ADDRESS <u>Mrs John Jacobson</u>		(2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 23, 1959</u> to <u>July 27, 1959</u> , that I last saw the deceased alive on <u>July 27, 1959</u> , and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral St., Annapolis, Md.</u> DATE SIGNED <u>7/28/59</u>			
ACTUAL SIGNATURE <u>Richard N. Peeler</u>		M.D. <u>121 Cathedral St., Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Richard N. Peeler</u>		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>JUL 30 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, and forward to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07492	
7481 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis					c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle THOMAS Last NAYLOR					4. DATE OF DEATH Month July Day 16 Year 19 59						
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/18/1901		9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Naylor, Sr.					14. MOTHER'S MAIDEN NAME Margarett Creek						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 577-18-2690		17. INFORMANT James Naylor, Best Gate Rd., Annapolis, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction due to Coronary Thrombosis due to Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (b) Disease (c), stating the underlying cause last, (c) DUE TO										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 		Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE Charles S. Petty					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/17/59				
EXAMINER'S NAME (Type) Charles S. Petty, M.D.					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)			
Burial		7-19-1959		St. John's Chapel		St. John's		Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Keen					ADDRESS 108 W. 4th St. U. S. Nat. Bldg.		24a. REC'D BY REGISTRAR DATE Jul 21 59		24b. REGISTRAR'S SIGNATURE Arthur J. Hume		

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA Co.</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore MD.</u>		d. STREET ADDRESS <u>2416 Pelham AVE.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOR ANNE General</u>						e. S. R. DENTED ON A F.A.R. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nubert E Nicholson</u>		First Middle Last		4. DATE OF DEATH <u>7 24 1959</u>		Year Month Day	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 25 1921</u>	
9. AGE (In years last birthday) <u>38</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRANSIT CO - BALTO</u>		11. BIRTHPLACE (State or foreign country) <u>Rock Mills Ind</u>	
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <u>Vinton Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>Jessie White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WW2</u>		16. SOCIAL SECURITY NO. <u>K14-76-5835</u>		17. INFORMANT <u>BERNADINE M. Nicholson</u>		Address <u>630 YALE AVE BALTO Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Struck by Lightning</u> DUE TO (b) <u>BURNS - of scalp - anterior chest - sudden</u> DUE TO (c) <u>Lacerations - bilateral</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by lightning</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> p.m. <u>24</u> 19 <u>59</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Town</u>		20f. (City or town) (County) (State) <u>AACO</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. L. Wharoff</u>		EXAMINER'S NAME (Type) <u>E. L. Wharoff</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7-24-59</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>28 JULY 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTONATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. H. G. & P. H. Walters</u>		ADDRESS <u>P.O. Box 1000</u>		24a. REC'D BY REGISTRAR <u>JUL 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

7483
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. 07494

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 10 Annapolis d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Murray Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis d. STREET ADDRESS 5 Murray Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE W NUTWELL		4. DATE OF DEATH Month Day Year JULY 28 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1872
9. AGE (In years last birthday) yrs 87		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Water Company	
11. BIRTHPLACE (State or foreign country) Anne Arundel Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Issac S. Nutwell		14. MOTHER'S MAIDEN NAME Roberta Winterson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-30-3591	
17. INFORMANT Mr. Stanton Nutwell - Son		Address Severna Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to (c) Interval between onset and death PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/28/59 to 7/28/59 , that I last saw the deceased alive on 7/28/59 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Annapolis, Maryland DATE SIGNED July 30, 1959			
ACTUAL SIGNATURE Elmer G. Linhardt MD		M.D. Annapolis, Maryland	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 31, 1959	22c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery	22d. LOCATION (City, town, or county) (State) Lothian, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Maryland	
24a. REC'D BY REGISTRAR AUG 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	



7484

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arudel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN TB 2 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Maryland	
3. NAME OF DECEASED (Type or print) First Sadie Middle O'HARA Last O'HARA		4. DATE OF DEATH Month July Day 8 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 7, 1885
9. AGE (In years lost birthday) 73 yrs		10. IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dietician		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Henry Edgell		14. MOTHER'S MAIDEN NAME Henrietta Heather	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 24, 19 59 to July 8, 1959 , that I last saw the deceased alive on July 8, 1959 , and that death occurred at 2:30PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7/8/59			
ACTUAL SIGNATURE Samuel Borssuck		M.D. Amos Garrett Blvd.	
PHYSICIAN'S NAME (Type) Samuel Borssuck		Annapolis, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/10/59	22c. NAME OF CEMETERY OR CREMATORY Spring Hill	22d. LOCATION (City, town, or county) Easton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.		24a. REC'D BY REGISTRAR DATE JUL 10 '59	24b. REGISTRAR'S SIGNATURE Arthur S. King

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07496

7525

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 42yr. 8mo. 3da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Josephine Middle Olney Last Olney				4. DATE OF DEATH Month 7 Day 27 Year 19 59			
5 SEX Female		6. COLOR OR RACE Negro		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 1893?	
9. AGE (In years last birthday) yrs 65		IF UNDER 1 YEAR Months 7 Days 27 Hours 19 Min 59		IF UNDER 24 HRS Months 7 Days 27 Hours 19 Min 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Ridgley				14. MOTHER'S MAIDEN NAME Susan West			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. - - -			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Subarachnoid Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Hypertensive Cardiovascular Disease associated with Generalized Arteriosclerosis (c) - - -							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - - -							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) - - -			
20c. TIME OF INJURY Month, Day, Year Hour a. m. - - - p. m. - - - 19 59				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - -	
20f. (City or town) - - -				(County) - - -		(State) - - -	
21. I certify that I attended the deceased from 11/24 , 19 16 , to 7/27 , 19 59 , that I last saw the deceased alive on 7/27 , 19 59 , and that death occurred at 5:30 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 5/27/59 ACTUAL SIGNATURE Lionel McHenry Mapp, M.D. M.D. Crownsville State Hospital, Md. 5/27/59 PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D. Crownsville State Hospital, Md. 5/27/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-29-59		22c. NAME OF CEMETERY OR CREMATORY Slopes Chapel		22d. LOCATION (City, town, or county) (State) Edgewater, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. Annapolis, Md.				ADDRESS - - -		24a. REC'D BY REGISTRAR MIL 29 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			



7485

CERTIFICATE OF DEATH

07497

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>a a</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>1 hr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West River</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Agnes MARION O'NEILL</u>		4. DATE OF DEATH Month Day Year <u>July 3 1959</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 28 1872</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West River, MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>West River, MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Phillip Mayhew</u>		14. MOTHER'S MAIDEN NAME <u>Catherine JENKINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Joseph H. O'NEILL, West River, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>cert.</u> 19 <u>56</u> , to <u>July 3</u> , 19 <u>59</u> ; that I last saw the deceased alive on <u>July 2</u> , 19 <u>59</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emily H. Wilson</u> M.D.		ADDRESS (Street, city or town, state) <u>Settlement, Md.</u> DATE SIGNED <u>7-6-59</u>	
PHYSICIAN'S NAME (Type) <u>Bernard Harold G. Wilson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/6/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of Sorrows</u>	22d. LOCATION (City, town, or county) (State) <u>West River Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Harold G. Wilson</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7526

CERTIFICATE OF DEATH

Reg. Dist. No.

07498

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade		c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenelg		d. STREET ADDRESS 1402 KENYON AVE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle Gertrude Last Penn				4. DATE OF DEATH Month July Day 14 Year 19 59			
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 June 1890	9. AGE (In years last birthday) 69 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jefferson Jackson Brown				14. MOTHER'S MAIDEN NAME Maggie Alice Massey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Brother: Address S.J. Brown 107 Gilmore St, Baltimore, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angiosarcoma, Metastatic 1977.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 13 July 19 59 to 14 July 19 59 , that I last saw the deceased alive on 14 July 19 59 , and that death occurred at 0255A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Army Hospital, Ft Meade, Md DATE SIGNED 14 Jul 59							
ACTUAL SIGNATURE Leon E. Kassel		M.D. U.S. Army Hospital, Ft Meade, Md					
PHYSICIAN'S NAME (Type) LEON E. KASSEL, MD,		U.S. Army Hospital, Ft Meade, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-17-1959	22c. NAME OF CEMETERY OR CREMATORY Morgan Chapel		22d. LOCATION (City, town, or county) (State) Carroll Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DATE JUL 17 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kessel

7486

CERTIFICATE OF DEATH

07499

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE Maryland b COUNTY Anne Arundel			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c LENGTH OF STAY IN TB 1 day			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Herbert Middle L Last PORTER				4. DATE OF DEATH Month July Day 12 Year 1959			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 31, 1910	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 48 Days 12 Hours 15 Min.		IF UNDER 24 HRS Months 48 Days 12 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Construction			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Walter Porter				14. MOTHER'S MAIDEN NAME Blanche Lippincott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-22-6514			
17. INFORMANT Francis Porter				Address 110-CLAY ST ANNAPOLIS, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage due to 443X DUE TO Hypertensive Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 12 hrs. (c) 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/12/59 to 7/14/59 that I last saw the deceased alive on 7/12/59 and that death occurred at 10:00 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 110-CLAY ST ANNAPOLIS, MD DATE SIGNED 7/14/59							
ACTUAL SIGNATURE R. H. Lawrence M.D.				PHYSICIAN'S NAME (Type) R. H. Lawrence			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7-16-1959		St. Charles		Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Keene				24a. REC'D BY REGISTRAR 14 59			
24b. REGISTRAR'S SIGNATURE Clifton S. Francis							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7527

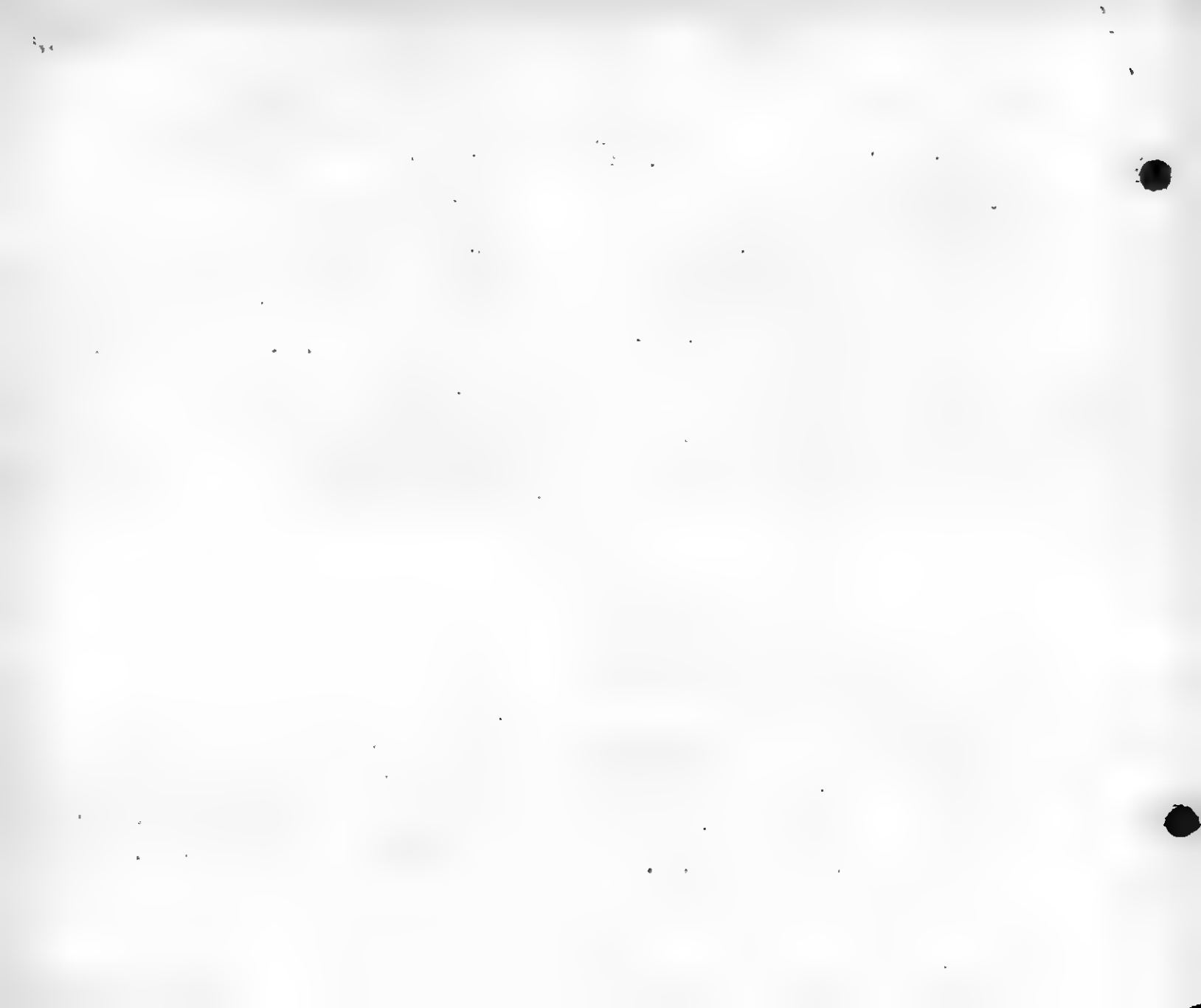
CERTIFICATE OF DEATH

07500

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 11mo. 2 years 25days							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1120 Barclay Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Sadie Middle Pratt Last Pratt				4. DATE OF DEATH Month 7 Day 14 Year 19 59			
5 SEX Female		6 COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 1896?	
9 AGE (In years last birthday) 63? yrs		IF UNDER 1 YEAR Months 63? Days 63? Hours 63? Min 63?		IF UNDER 24 HRS Months 63? Days 63? Hours 63? Min 63?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown				16 SOCIAL SECURITY NO. Unknown		INFORMANT Hospital Records Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Bronchopneumonia + Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephrosis DUE TO (c) Diabetes Mellitus							
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----			
20c TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 59 p. m. -----				20d INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>			
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----				20f (City or town) (County) (State) -----			
21. I certify that I attended the deceased from 7/19 1956 to 7/14 1959 , that I last saw the deceased alive on 7/14 1959 , and that death occurred at 7:45P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Benedict, M. D. M.D.				ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 7/15/59			
PHYSICIAN'S NAME (Type) L. Benedict, M. D.				ADDRESS Crownsville State Hospital, Md. DATE SIGNED 7/15/59			
22a BURIAL, CREMATION, REMOVAL (Specify) 7-21-59		22b. DATE THEREOF 7-21-59		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON		22d. LOCATION (City, town, or county) (State) ARLINGTON, VA.	
23. FUNERAL DIRECTOR'S SIGNATURE W. ERNEST JARVIS C. ADDRESS 1432 400 ST. N.W.				24a. REC'D BY REGISTRAR DATE JUL 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7528

CERTIFICATE OF DEATH

07501

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>W. Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>W. Baltimore</u>		d. STREET ADDRESS <u>W. Baltimore</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret Keirne</u>		4. DATE OF DEATH <u>July 1, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26, 1923</u>
9. AGE (In years last birthday) <u>33</u> yrs		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Conn. Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Andrew</u>		14. MOTHER'S MAIDEN NAME <u>Keirne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Walter Andrew</u>		Address <u>W. Baltimore</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Carcinoma of Breasts & Metastases</u> DUE TO (c) <u>Heart exhaustion</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>Several Days</u> <u>Unknown</u> <u>One Day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 10, 1959</u> to <u>July 1, 1959</u> , that I last saw the deceased alive on <u>June 30, 1959</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H. Hunt</u> M.D.		DATE SIGNED <u>July 2, 1959</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD H. HUNT</u>		<u>100 Cherry Lane Glen Burnie</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-30-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>W. Baltimore</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Baltimore</u>		ADDRESS <u>W. Baltimore</u>	
24a. REC'D BY REGISTRAR <u>W. Baltimore</u>		24b. REGISTRAR'S SIGNATURE <u>W. Baltimore</u>	
DATE <u>JUL 10 '59</u>			



7529 CERTIFICATE OF DEATH

07502

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel County OLEY F. RINGLER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn				c. LENGTH OF STAY IN 1b Brooklyn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 219 Meadow Rd.				d. STREET ADDRESS 219 Meadow Rd.			
3. NAME OF DECEASED (Type or print) First OLEY Middle F. Last RINGLER				4. DATE OF DEATH Month 7 Day 3 Year 19 59			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/29/92		9. AGE (In years last birthday) yrs. 66	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder			10b. KIND OF BUSINESS OR INDUSTRY USCG		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Guy Ringler				14. MOTHER'S MAIDEN NAME Marian Spencer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] NO		16. SOCIAL SECURITY NO -		17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myeloid Leukemia 4.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1 April , 19 57 to 3 July , 19 59 , that I last saw the deceased alive on 2 July 59 , 19 59 , and that death occurred at 7 P. M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Andrew R Sosnowski M.D. 4016 Ritchie Hwy 6 July 59 PHYSICIAN'S NAME (Type) Andrew R Sosnowski Balto 25-nd							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7/7/59		Cedar Hill Cem.		Brooklyn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McGully Funeral Homes 130 E. Fort Ave.				24a. REC'D BY REGISTRAR DATE JUL 8 '59		24b. REGISTRAR'S SIGNATURE Arthur A. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7530 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07503

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odonton</u>		d. STREET ADDRESS <u>Route 175</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Schulte Ford Dealer, N. Ritchie Highway</u>				e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Homer Lee Ritz</u>				4. DATE OF DEATH Month <u>July</u> Day <u>24th.</u> Year <u>19 59</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1/31/14</u>	9. AGE (In years last birthday) <u>45</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook and baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canton, Ohio</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Roy Ritz</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Gump</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>11 World War (Army)</u>		16. SOCIAL SECURITY NO. <u>574-61-7894</u>		17. INFORMANT <u>Mr. Robert W. Kramer, 8 W. Barney St. Baltimore.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				DATE SIGNED <u>7/24/59</u>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION. REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-30-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, 6009 Harford Road, ZONE 14</u>				24a. REC'D BY REGISTRAR <u>DATE JUL 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kramer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7531
CERTIFICATE OF DEATH

07504

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>37 years 5mo. 6 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				2 USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>Unknown</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louise</u> <u>Robinson</u>				4. DATE OF DEATH Month Day Year <u>7</u> <u>8</u> <u>19 59</u>					
5 SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>1893</u>		9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James M. Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT <u>Hospital Records</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> <u>443X</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>Hypertensive Cardiovascular Disease</u> (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>-----</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>4:15</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) (County) (State) <u>-----</u>			
21. I certify that I attended the deceased from <u>2/2</u> , 19 <u>22</u> , to <u>7/8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/8</u> , 19 <u>59</u> and that death occurred at <u>-----</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>7/8/59</u> ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D. <u>Crownsville State Hospital, Md.</u> 7/8/59 PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u> <u>Crownsville State Hospital, Md.</u> 7/8/59									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>7-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Crown. Md.</u>				ADDRESS <u>-----</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7487 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07506

Reg. Dist. No.

FOR STATE
HEALTH DEPT

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA ANNE ARUNDEL GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>292 WEST STREET</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM DANIEL SANDERS</u>				4. DATE OF DEATH Month Day Year <u>JULY 2 19 59</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>JANUARY 10, 1898</u>	
9. AGE (in years last birthday) <u>61</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. LT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY</u>		11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>WILLIAM H. SANDERS</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE A. DOUGHERTY</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I and II</u> Unknown	
16. SOCIAL SECURITY NO <u>Unknown</u>				17. INFORMANT <u>RUBY LEE SANDERS - WIFE - same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ </div> <div style="width: 35%; text-align: center;"> CORONARY DISEASE YRS </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Causes</u>				20c. TIME OF INJURY Month, Day, Year Hour <u>xxx</u> <u>July 2</u> <u>19 59</u> p m			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Annapolis, Anne Arundel, Md.</u>				20g. (County) <u>Anne Arundel</u>			
20h. (State) <u>Md.</u>				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Elmer G. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>July 2, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>July 6, 1959</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				24a. REC'D BY REGISTRAR <u>DATE JUL 6 '59</u>			
ADDRESS <u>HOPPING FUNERAL HOME, Annapolis, Maryland</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7532

CERTIFICATE OF DEATH

07507

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A. Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE <i>MD</i> b. COUNTY <i>A. H. Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CLAVATON HYS</i>		c. LENGTH OF STAY IN 1b <i>6 YRS</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>CBRECHT RD - RT 1 BOX 758A</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CLAVATON HYS</i>	
3. NAME OF DECEASED (Type or print) <i>HENRY J. SCHAEFER</i> First Middle Last		4. DATE OF DEATH <i>JULY 13 1959</i> Month Day Year	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>17 NOV 1876</i>
9. AGE (In years last birthday) <i>82 yrs.</i>		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SOLDIER (RET)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>ENAMELING CO</i>	
11. BIRTHPLACE (State or foreign country) <i>BALTO MD</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>HENRY SCHAEFER</i>		14. MOTHER'S MAIDEN NAME <i>NOT KNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>45-03-3083A</i>	
17. INFORMANT <i>MANIE E. HEBLER</i> Address <i>CBRECHT RD RT 1 BOX 758A</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X Cerebral Hemorrhage</i> DUE TO (b) <i>generalized arteriosclerosis</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <i>6 days several years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>October 15, 1953</i> , to <i>July 13, 1959</i> , that I last saw the deceased alive on <i>July 12, 1959</i> , and that death occurred at <i>8:15 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R.M. McLaughlin</i> M.D.		DATE SIGNED <i>RF08 Box 442 Pasadena, Md July 13, 1959</i>	
PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>16 JULY 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>London Park Cme</i>	22d. LOCATION (City, town, or county) (State) <i>BALTO MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter B. M. Walters</i> ADDRESS <i>RAH - Spitzer</i>		24a. REC'D BY REGISTRAR <i>14 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Orlino S. Thomas</i>

7488

CERTIFICATE OF DEATH

07508

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. STREET ADDRESS Sparrows Beach			
3. NAME OF DECEASED (Type or print) First Oliver Middle SELLMAN Last SELLMAN				4. DATE OF DEATH Month July Day 15 Year 19 59			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 24, 1900	9. AGE (In years last birthday) 58 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Henry Clay Sellman				14. MOTHER'S MAIDEN NAME Roscoe Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no for unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219-01-0604			
17. INFORMANT William Sellman				Address 104 Clingman St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Stomach with 151X DUE TO Metastases to Liver, Regional DUE TO Acute Medialateral Lymph Node Lung PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Edema due to congestive heart failure							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 10, 19 59 to July 14, 19 59 that I last saw the deceased alive on July 14, 19 59 , and that death occurred at 3:40AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Raymond L. Richardson				M.D. 110 Clay St.,		DATE SIGNED 7/15/59	
PHYSICIAN'S NAME (Type) Raymond L. Richardson				Annapolis, Md.			
22a. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7-19-1959		St. John's Church		Lithuanian	
23. FUNERAL DIRECTOR'S SIGNATURE William H. 108 Wash St. Annapolis Md				24a. REC'D BY REGISTRAR DATE JUL 21 '59		24b. REGISTRAR'S SIGNATURE C. S. 8 Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
BM 2/57

7533

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07509

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Arnold</u> c. LENGTH OF STAY IN 1b <u>2 1/2 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 75</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs BERTHA JOSEPHINE SHOWE</u> First Middle Last 4. DATE OF DEATH <u>July 4</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OF RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8/14/88</u> 9. AGE (in years last birthday) <u>70</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Nurse</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Hagerstown, Md.</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Henry Switzer</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO <u>-----</u>		14. MOTHER'S MAIDEN NAME <u>Mary Josephine Lawrence</u> 17. INFORMANT <u>Mrs. Jean Wm. SHOWE (Sow)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 241X DUE TO (b) <u>Chronic Bronchial Asthma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>431</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H Faubert, M.D.</u> EXAMINER'S NAME (Type) <u>GUSTAVE-H FAUBERT, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7/4/59</u>	
22a. BURIAL CREMATION—REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 7 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/

7489 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

07510

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				/d. STREET ADDRESS X Galesville			
3. NAME OF DECEASED (Type or print) First Eva Middle Mae Last SMITH				4. DATE OF DEATH Month July Day 18 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 3, 1887	
9. AGE (In years lost birthday) yrs. 71 1/2		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME George Kirchner				14. MOTHER'S MAIDEN NAME Maggie Joyce			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no none				16. SOCIAL SECURITY NO. Ernest H. Smith- Husband- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis DUE TO (b) with brain hemorrhage DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from July 3, 1959 to July 18, 1959 , that I last saw the deceased alive on July 18, 1959 , and that death occurred at 10:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Emily H. Wilson				ADDRESS (Street, city or town, state) Lothian, Md.		DATE SIGNED 7/20/59	
PHYSICIAN'S NAME (Type) Emily H. Wilson				Lothian, Md.			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF July 21, 1959		22c. NAME OF CEMETERY OR CREMATORY Woodfields Cemetery		22d. LOCATION (City, town, or county) (State) Galesville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR DATE JUL 22 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline							

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7490
CERTIFICATE OF DEATH

07511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 1200 West St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas A SMITH Sr				4. DATE OF DEATH Month Day Year July 14 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 19, 1887	
9. AGE (In years last birthday) 71 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor Bldg.		10b. KIND OF BUSINESS OR INDUSTRY Masonry Cont.		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Thomas Smith			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. INFORMANT				17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma toxic 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Gall Bladder DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						18. INTERVAL BETWEEN ONSET AND DEATH 2 wks. 4 wks.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from April 5, 1953 to 7-14-1959 that I lost saw the deceased olive on 7-14-1959 and that death occurred at 5:30 P M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James R. Martin M.D.				ADDRESS (Street, city or town, state) 6 Shaw St., DATE SIGNED 7/15/59			
PHYSICIAN'S NAME (Type) James R. Martin				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF July 17-59			
22c. NAME OF CEMETERY OR CREMATORY Glenn Haven Memorial				22d. LOCATION (City, town, or county) (State) Glenn Burne Md			
23. FUNERAL DIRECTOR'S SIGNATURE John M. Sayles ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR DATE JUL 16 '59			
24b. REGISTRAR'S SIGNATURE Colton S. Kane							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 4 21-11-4 7-17-59 et

7534

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAZER</u>	c. LENGTH OF STAY IN 1b <u>10 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X LAZEL MD ROUTE 1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LAZERA</u> Middle <u>SPRUELL</u> Last <u>SPRUELL</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 14, 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MAID</u>	
11. BIRTHPLACE (State or foreign country) <u>WARREN CO. N. CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN SPRUELL</u>		14. MOTHER'S MAIDEN NAME <u>NANCY BOYD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>238-76-7047</u>	
17. INFORMANT Address <u>ELIZA HOLMAN, ROUTE 1, BOX 166 LAZEL MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> DUE TO (b) <u>cardiac failure</u> DUE TO (c) <u>cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-23</u> , 19 <u>59</u> , to <u>7-11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-6</u> , 19 <u>59</u> , and that death occurred at <u>1 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Pololo S. Alexandri</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>July 15, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROANOKE CHAPEL</u>	22d. LOCATION (City, town, or county) (State) <u>WELDON N. CAROLINA</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUL 14 59</u>	24b. REGISTRAR'S SIGNATURE <u>Calvin E. Hines</u>

7491

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN TB 1 1/2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS RFD-1			
3. NAME OF DECEASED (Type or print) First Mamie Middle (Mary Estelle) Last STALLINGS				4. DATE OF DEATH Month July Day 17 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1886	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 73 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Anne Arundel Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert L. Gray				14. MOTHER'S MAIDEN NAME Mary E. Boyd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mr. Henry B. Stallings		Address Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular disease DUE TO (b) Paralysis of stomach DUE TO (c) 2nd degree burn on chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 7, 1959 to July 17, 1959 that I last saw the deceased alive on July 17, 1959 , and that death occurred at 2:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3 Chesapeake Ave., Annapolis, Md. DATE SIGNED 7/17/59							
ACTUAL SIGNATURE Elmer G. Linhardt				M.D. 3 Chesapeake Ave., Annapolis, Md.			
PHYSICIAN'S NAME (Type) Elmer G. Linhardt				Ann timer, Md.			
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 20 July 1959		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Meth. Ch. Cem. Mt. Rd. Pasadena, Md.		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton - Glen Burnie, Md.				ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE JUL 21 '59	
				24b. REGISTRAR'S SIGNATURE Charles S. Hanes			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7535

CERTIFICATE OF DEATH

07514
Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G. Meade</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		d. STREET ADDRESS <u>Route #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lowell</u> Middle <u>Thomas</u> Last <u>Staubitz Jr</u>		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 July 1959</u>
9. AGE (In years last birthday) <u>3</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lowell Thomas Staubitz</u>		14. MOTHER'S MAIDEN NAME <u>Carlenda Elizabeth Timmons</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mother</u>		Address <u>Mrs Lowell Thomas Staubitz, Sykesville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity, 32 weeks</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>716 X</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1959</u> Hour <u>12</u> o. m. <u>30</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6 July</u> , 19 <u>59</u> , to <u>9 July</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9 July</u> , 19 <u>59</u> , and that death occurred at <u>1230P</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>U.S. Army Hospital, Ft Meade, Md</u> DATE SIGNED <u>9 Jul 59</u>			
ACTUAL SIGNATURE <u>R. G. Meyer</u>		PHYSICIAN'S NAME (Type) <u>ROGER C. MEYER, CAPT, MC, US ARMY HOSPITAL, FT GEORGE G. MEADE, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-12-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Freedom</u>		22d. LOCATION (City, town, or county) (State) <u>Carderburg, Carroll, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederic H. Wright</u>		ADDRESS <u>Sykesville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Richard S. Frank</u>	

7492

CERTIFICATE OF DEATH

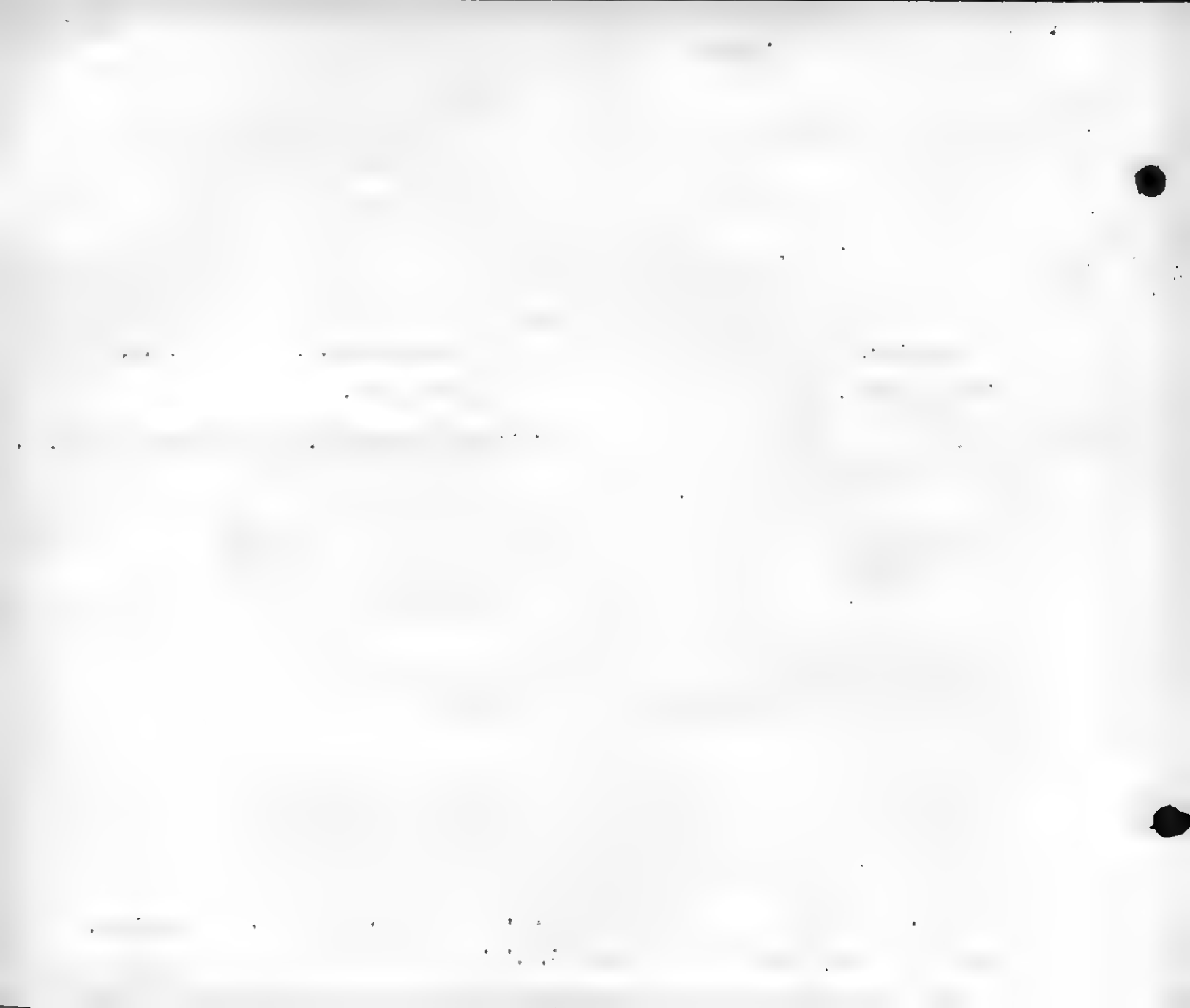
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>3025 N. Oakland</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DOROTHY</u> Middle <u>SUMMERBELL</u> Last <u>SUMMERBELL</u>		4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/17/19</u>
9. AGE (In years lost birthday) yrs <u>40</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u> Hours <u>19</u> Min <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry L Selby.</u>		14. MOTHER'S MAIDEN NAME <u>Lillie Simms.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>William E Summerbell, 3025 N. Oakland St. Arl. Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u> <u>17 yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/5</u> , 19 <u>59</u> to <u>7/6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/6</u> , 19 <u>59</u> and that death occurred at <u>12:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST</u> DATE SIGNED <u>7/6/59</u> ACTUAL SIGNATURE <u>Richard N. Peeler</u> M.D. <u>RICHARD N. PEELER</u> ANNAPOLIS, MD. PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u> ANNAPOLIS, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial.</u>	22b. DATE THEREOF <u>7/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery, Fort Myer, Virginia.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F Birch, s Sons 3034 M Street, N.W.</u>		24a. REC'D BY REGISTRAR <u>AUG 8 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

MEDICAL CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7536 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07516

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If in hospital, give street address) <u>WOODCLIFF BEACH</u>		e. STREET ADDRESS <u>WOODCLIFF BEACH PINE WHIFF BEACH</u>	
3. NAME OF DECEASED (Type or print) First <u>MAUDE</u> Middle <u>KEENER</u> Last <u>SWINDELL</u>		4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/31/83</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>	11. BIRTHPLACE (State or foreign country) <u>TENNESSEE</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JAMES WILSON KEENER</u>	
14. MOTHER'S MAIDEN NAME <u>MARY JANE LEWIS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs. Wm. C. MacMillan, 8416 Woodcliff Ct., Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (c) <u>due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> P. M. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		DATE SIGNED <u>7/24/59</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Geo. County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. H. H. H.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7537

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07517

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Orchard Beach		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Orchard Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1220 Riverside Dr.		d. STREET ADDRESS 1220 Riverside Dr.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle G. Last TAAFE		4. DATE OF DEATH Month 7 - Day 6 - Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-10-98
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 6 Days 1 Hours 1 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Taafe		14. MOTHER'S MAIDEN NAME Lena	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Flora Taafe		Address Orchard Beach Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the throat DUE TO 18X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 22, 1959 , to July 6, 1959 , that I last saw the deceased alive on July 5, 1959 , and that death occurred at 6:50 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R.M. McLaughlin		ADDRESS (Street, city or town, state) RFD 8 Box 442 Pasadena, Md.	
PHYSICIAN'S NAME (Type) R.M. McLaughlin		DATE SIGNED July 6, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-9-59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem	22d. LOCATION (City, town or county) (State) Brooklyn MD
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home		24a. REC'D BY REGISTRAR DATE JUL 8 59	
ADDRESS 130 E Fort Ave		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 ISM 9/7

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

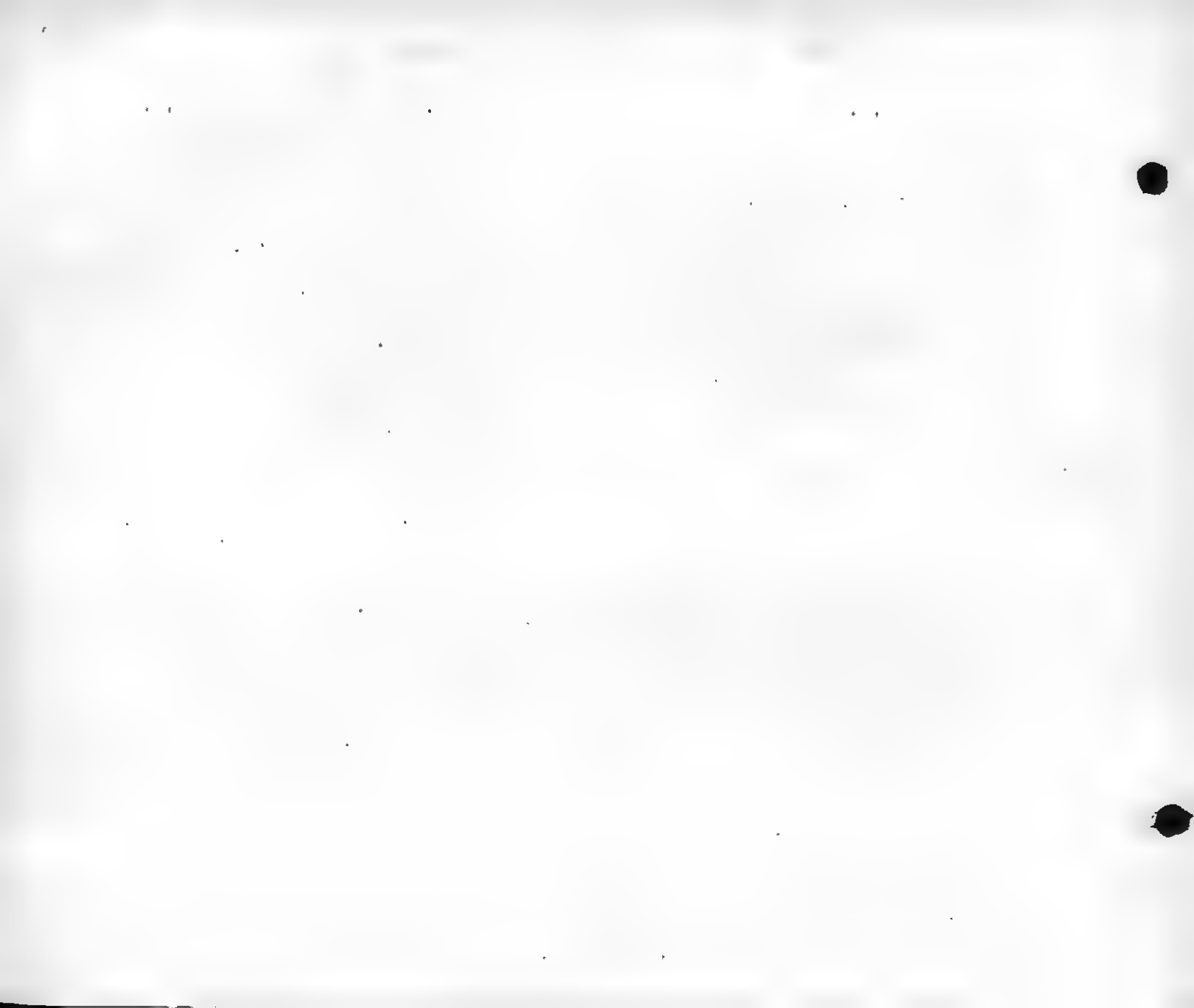
7538

CERTIFICATE OF DEATH

07518

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A.A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE MD. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKLYN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKLYN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4509 RITCHIE HIGHWAY		d. STREET ADDRESS 4509 RITCHIE HIGHWAY	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN O. TAYLOR		4. DATE OF DEATH Month Day Year 7/20/59 19	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/75
9. AGE (In years last birthday) yrs 84		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRODUCE DEALER		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JACKSON TAYLOR		14. MOTHER'S MAIDEN NAME HATTIE PARKS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. INFORMANT Address FAMILY - SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) Chronic hypertrophic arthritis (?)			INTERVAL BETWEEN ONSET AND DEATH 4 hours 2-3 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/14 , 19 59 , to 7/20 , 19 59 , that I last saw the deceased alive on 7/20 , 19 59 , and that death occurred at 5:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry Deibel M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 1226 Hanover St. Baltimore 30 Md 7/21/59	
PHYSICIAN'S NAME (Type) HARRY DEIBEL M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) B	22b. DATE THEREOF 7/23/59	22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK	22d. LOCATION (City, town, or county) (State) BALTIMORE
23. FUNERAL DIRECTOR'S SIGNATURE MCCULLY FUNERAL HOMES - 130 E. FORT AVE.		24a. REC'D BY REGISTRAR DATE JUL 24 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7539

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

07519

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut on: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>9/20/1959</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>1406 W Lenuale St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>F.</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>may 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEVERING BANTHEM</u>		14. MOTHER'S MAIDEN NAME <u>ELIZA</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Hospital record. -Crownsville</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Cerebral embolus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>schizophrenic React. undiff. type</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/20/59</u> 19 <u>59</u> , to <u>7/24/59</u> 19 <u>59</u> , that I last saw the deceased alive on <u>7/24/59</u> 19 <u>59</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>CROWNVILLE STATE HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>L. RENEDELL M.D.</u>		DATE SIGNED <u>CROWNVILLE, MD</u>	
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b DATE THEREOF <u>7/28/59</u>	
22c NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>		22d LOCATION (City, town, or county) (State) <u>BALTO - MD</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Mano...</u>		ADDRESS	
24a DEC'D BY REGISTRAR <u>JUL 27 '59</u>		24b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
18M 9/58

7540

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07520

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian</u>	
c. LENGTH OF STAY IN 1b <u>3 yr. 11 da.</u>		d. STREET ADDRESS <u>None</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Georgianna</u> Middle <u>(alias Thompson)</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1892</u>
9. AGE (In years last birthday) <u>66</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jimmy Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Georgianna</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16 SOCIAL SECURITY NO. <u>-</u>	
INFORMANT <u>Hospital Records</u>		Address <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>7/20</u> , 19 <u>56</u> , to <u>7/31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/31</u> , 19 <u>59</u> , and that death occurred at <u>9:30</u> A. M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Lionel McHenry Mapp, M.D.</u>		DATE SIGNED <u>7/31/59</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M.D.</u>		ADDRESS (Street, city or town, state) <u>Crownsville State Hosp., Md.</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial Aug. 3, 59</u>		22b. DATE THEREOF <u>Aug. 3, 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Church, Friendship</u>		22d. LOCATION (City, town, or county) <u>Friendship, Md.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>LeRoy E. Barry, Huntingtown, Md.</u>		24a REC'D BY REGISTRAR <u>AUG 4 '59</u>	
24b REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>		24c REGISTRAR'S SIGNATURE <u> </u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)
15M 9/58

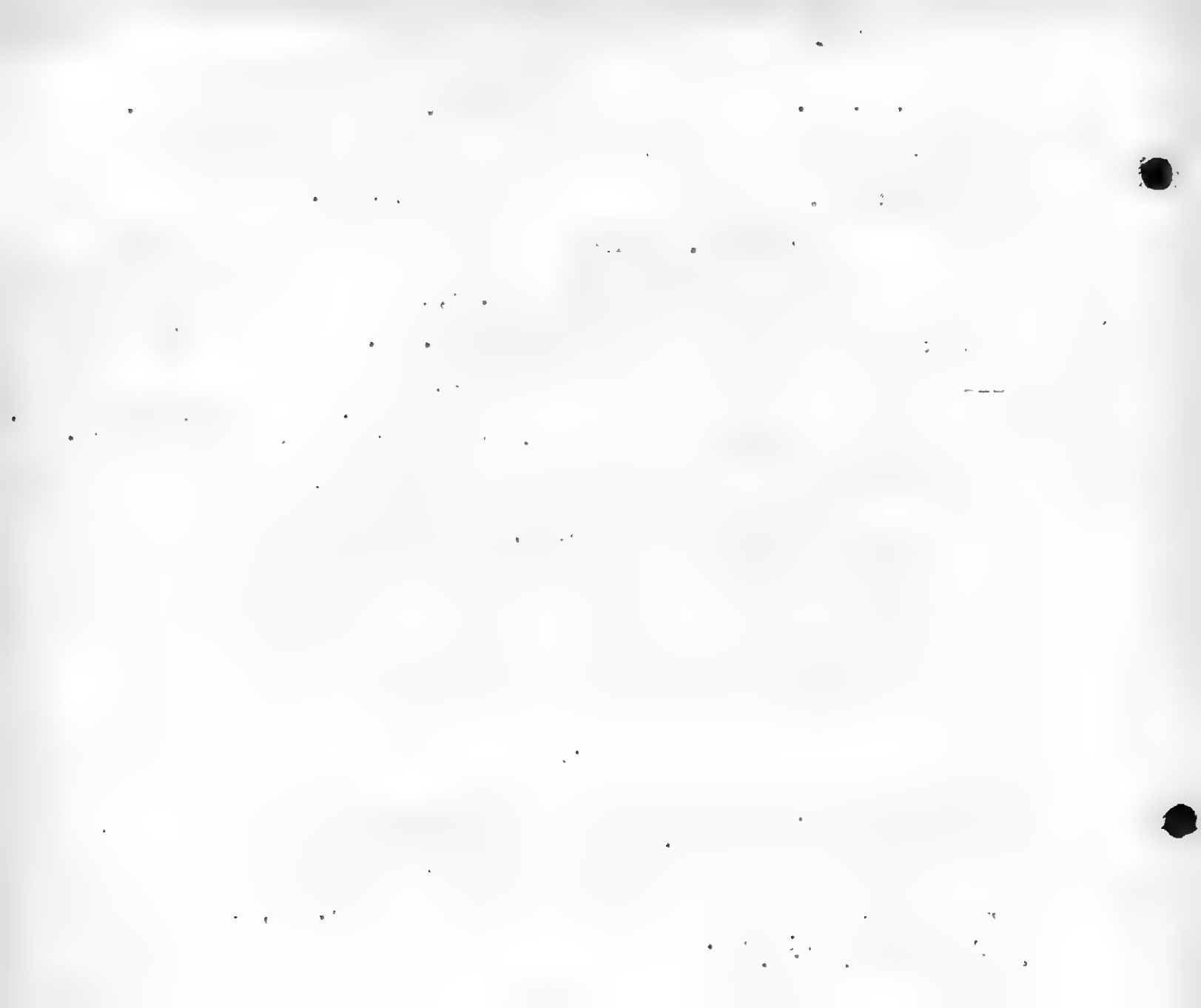
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1 X
3 7541 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

07521

1 PLACE OF DEATH a. COUNTY A. A. Co. MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Ma. b. COUNTY AA Co.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale		c LENGTH OF STAY IN 1b 6 months	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale		d. NAME OF HOSPITAL (If not in hospital, give street address) 402 Melrose Rd.	
d. STREET ADDRESS 402 Melrose Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albert H. Middle Thompson Last		4. DATE OF DEATH Month July Day 20 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1890
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce		10b. KIND OF BUSINESS OR INDUSTRY Balto. Md.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thompson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO 218 03 0131	
17. INFORMANT (daughter) Mrs. Alveta Gouldin		Address Ferndale Md. 402 Melrose Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR HEMORRHAGE DUE TO 131X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL ATHEROSCLEROSIS DUE TO (c) 15YRS.		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 15YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-25 , 19 59 to 7-20 , 19 59 , that I last saw the deceased alive on 7-10 , 19 59 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leon C. Perry		M.D. 201 B & A BLVD	
PHYSICIAN'S NAME (Type) GLEN BURNIE,		DATE SIGNED 7-21-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 23/59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Balto. 29, Md	
23. FUNERAL DIRECTOR'S NAME AND ADDRESS W. L. & S. Funeral Directors 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE JUL 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			



7493

CERTIFICATE OF DEATH

07522

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b Annapolis d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Riva d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Label Merrick Tilghman		4. DATE OF DEATH Month Day Year July 31 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1899
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (State or foreign country) Harford County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Annie Miles Riley		14. MOTHER'S MAIDEN NAME Caleb M. Merrick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO no	
17. INFORMANT Mr. Thomas O. Tilghman Sr.		Address Husband asme as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Several	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/31/59 to 7/31/59 , that I last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Albert L. Anderson		DATE SIGNED 7/31/59	
PHYSICIAN'S NAME (Type) Dr. Albert L. Anderson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF AUGUST 2, 1959	22c. NAME OF CEMETERY OR CREMATORY Southern Methodist Cemet.	22d. LOCATION (City, town, or county) (State) Dublin, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		24a. REC'D BY REGISTRAR AUG 3 '59	
ADDRESS Annapolis, Md.		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7494

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut an Residence before admission) a. STATE <u>md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>U.S. General</u>		d. STREET ADDRESS <u>1317 First St</u>	
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Tompkins</u> Last <u>Tomaszewski</u>		4. DATE OF DEATH Month <u>7</u> Day <u>22</u> Year <u>1959</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug 4-1895</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Joiner</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Ship Yard</u>	
11 BIRTHPLACE (State or foreign country) <u>Phila Pa</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>Samuel Tomaszewski</u>		14 MOTHER'S MAIDEN NAME <u>Unknown</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16 SOCIAL SECURITY NO <u>1-NN-1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Coronary Artery Disease</u> DUE TO <u>Unknown</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ventricular Tachycardia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 wks</u>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part-II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-6</u> , 19 <u>59</u> , to <u>7-22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-22</u> , 19 <u>59</u> , and that death occurred at <u>1:25</u> P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Edward S Beck</u>		DATE SIGNED <u>7/22/59</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD S BECK</u>		ADDRESS (Street, city or town, state) <u>41 Southgate Ave Annapolis, Md.</u>	
22a BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7-27-59</u>	<u>US GOVERNMENT NAT. CEM.</u>	<u>BEVERLY N. J.</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		24a REC'D BY REGISTRAR <u>DATE JUL 27 '59</u>	
ADDRESS <u>Annapolis Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)
15M 9/58

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7495

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Port - Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>		d. STREET ADDRESS <u>403 Chesapeake Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Clarence A. Turner</u>		4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-9-1911</u>
9. AGE (In years last birthday) <u>48</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Acad. East Port, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Solomon Turner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Blunt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-267616</u>	
INFORMANT <u>Catherine Turner - East Port, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Vascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/7</u> 19 <u>59</u> to <u>7/29</u> 19 <u>59</u> that I last saw the deceased alive on <u>7/29</u> 19 <u>59</u> and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. Johnson</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>7/30/59</u>	
PHYSICIAN'S NAME (Type) <u>DR. THEODORE H. JOHNSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>8-1-59</u>	<u>Brewer Hill</u>	<u>Annapolis, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keese, Jr. - Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 30 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7542

CERTIFICATE OF DEATH

07525

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carrollton Manor</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carrollton Manor, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rte 2, Box 547 Severna Park</u>				d. STREET ADDRESS <u>Knollwood Rd. Park</u>			
3. NAME OF DECEASED (Type or print) <u>Edwin McCellen Warrenberg</u>				4. DATE OF DEATH <u>7-30-59</u> 19			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 25 1904</u>	
9. AGE (In years last birthday) <u>55</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. City</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>George W. Warrenberg</u>				14. MOTHER'S MAIDEN NAME <u>Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO <u>219-071-1986</u>		17. INFORMANT <u>Wife</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> DUE TO (b) <u>Emphysema (Pulmonary)</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1954</u> , 19, to <u>1959</u> , 19, that I last saw the deceased alive on <u>7-29-59</u> , 19, and that death occurred at <u>4 A.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert Hahn, M.D.</u>				ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>7-30-59</u>			
PHYSICIAN'S NAME (Type) <u>Robert Hahn, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/1/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & KIRKLEY</u> ADDRESS <u>Glen Burnie, Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. K...</u>	

7543

CERTIFICATE OF DEATH

07525

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HEARLD HARBUR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SANN'S NURSING HOME</u>		d. STREET ADDRESS <u>HAZEL TRAIL</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Eleonora</u> First <u>—</u> Middle <u>—</u> Last <u>WILKES</u>		4. DATE OF DEATH <u>7-30-1959</u> Month <u>7</u> Day <u>30</u> Year <u>1959</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/14/1880</u> 9 AGE (In years last birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ROBERT E. SCAGGS</u>		14. MOTHER'S MAIDEN NAME <u>PETERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <u>—</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute & fatal pneumonia</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1-59</u> to <u>July 30-59</u> , that I last saw the deceased alive on <u>July 29-59</u> , and that death occurred at <u>530 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. Joseph Lipsky</u>		ADDRESS (Street, city or town, state) <u>Odenton, Md.</u>	
PHYSICIAN'S NAME (Type) <u>DR. JOSEPH LIPSKY</u>		DATE SIGNED <u>7/30-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 3, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Maryland</u>	
24a REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>		24b REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07527

7496

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 184 Duke of Gloucester		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Agnes Middle E. Last WINCHESTER				4. DATE OF DEATH Month July Day 28 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1889		9. AGE (In years lost birthday) 70 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Patrick Lamb				14. MOTHER'S MAIDEN NAME Budget Hogan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO INFORMANT		Address Francis O. Winchester (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 DUE TO Asotemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic glomerular nephritis (c) Arteriosclerosis generalized						INTERVAL BETWEEN ONSET AND DEATH 5 days 1 yr. 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January , 1955, to July 28 , 1959, that I last saw the deceased alive on July 28 , 1959, and that death occurred at 6:10 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) 6 Shaw St., Annapolis, Md. DATE SIGNED 7/29/59							
ACTUAL SIGNATURE James R. Martin				M.D. 6 Shaw St., Annapolis, Md.			
PHYSICIAN'S NAME (Type) James R. Martin				Ann Arbor, Md.			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		July 31-59		St. Mary's Cem.		Annapolis Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor				ADDRESS Annapolis Md.		24a. REC'D BY REGISTRAR DATE JUL 30 '59	
				24b. REGISTRAR'S SIGNATURE Christina S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film G246 7-31-59 et

7544

CERTIFICATE OF DEATH

07528

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sauns Nursing Home		d. STREET ADDRESS Maryland Ave	
3. NAME OF DECEASED (Type or print) Ruth Nellie M. Wooden		4. DATE OF DEATH July 23 1959	
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Aug. 99
9. AGE (In years last birthday) 60		10. UNDER 1 YEAR IF UNDER 24 HRS. 39	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. wife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Johnstown Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard W. Walton		14. MOTHER'S MAIDEN NAME Nellie Leightner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wilbur E. Wooden		Address Severn Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub Arterial Hemorrhage 443X DUE TO Hypertensive Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sclerotic Cardio Vascular Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Hour a. m. — p. m. — 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) — (County) — (State) —	
21. I certify that I attended the deceased from June 1 1959 to July 23 1959 , that I last saw the deceased alive on July 23 1959 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Febus Grunberg M.D.		ADDRESS (Street, city or town, state) P.O. Box 37 Odenton, Md	
PHYSICIAN'S NAME (Type) Febus Grunberg		DATE SIGNED 7/24/1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 27 July 59	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven		22d. LOCATION (City, town, or county) (State) Glen Burnie Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. J. S. Sington		ADDRESS Glen Burnie Md.	
24a. REC'D BY REGISTRAR JUL 27 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kneel	

MEDICAL CERTIFICATION

11.758

CERTIFICATE OF DEATH

2524

County of Maryland

State of Maryland

Grave 000001

Millstone Bridge

Maryland

Grave 000001

Grave 000001

Grave 000001

Grave 000001

Grave 000001

Grave 000001

Grave 000001

Grave 000001

Grave 000001

Grave 000001

Grave 000001

Grave 000001

Grave 000001

Grave 000001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
7497
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 8 FilmG244 7-21-59 et
CERTIFICATE OF DEATH

07529

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 731 Glenwood Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Sarah Middle ZELKOWITZ Last ZELKOWITZ				4. DATE OF DEATH Month July Day 10 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1866 November 15, 1876	
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Unknown Block				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c) Diabetes mellitus							INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 4, 1959 , to July 10, 1959 , that I last saw the deceased alive on July 10, 1959 , and that death occurred 12:35 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John Hedeman				ADDRESS (Street, city or town, state) 121 Cathedral St., Annapolis, Maryland		DATE SIGNED 7/11/59	
PHYSICIAN'S NAME (Type) John Hedeman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 12, 1959		22c. NAME OF CEMETERY OR CREMATORY Kneseth Israel Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE JUL 16 1959	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

